

Clinical Briefs in **Primary Care**

The essential monthly primary care update

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Telithromycin Impact in Acute Asthma

Source: Johnston SL, et al. *N Engl J Med.* 2006;354:1589-1600.

MOST EXACERBATIONS OF ASTHMA are related to viral infection. Hence, antibiotics are usually not useful unless there is a suspicion of bacterial infection. Indeed, a Cochrane review of antibiotics in asthma identified 2 prior studies in which antibiotics (not telithromycin [TEL]) provided no benefit for acute asthma exacerbations.

TEL is a macrolide antibiotic with effects on atypical bacteria that are sometimes recovered during acute asthma exacerbations, and often colonize patients with asthma, eg, *Chlamydia* and *Mycoplasma*. TEL also possesses some immunomodulatory effects. This study compared TEL 800 mg/d with placebo for patients with acute asthma exacerbations (n = 278). The end points were changes in symptoms and peak expiratory flow rate (PEFR).

Although TEL treatment was not superior to placebo for PEFR, there was a statistically significant effect on symptoms favoring TEL. Subgroup analysis of *Chlamydia/Mycoplasma serostatus* indicated that subjects who were bacteria sero-positive did enjoy a statistically significant improvement in FEV₁ compared to sero-negative subjects. The role of serostatus is uncertain, since only a very small percentage of subjects were PCR-positive for bacteria, which should be a more sensitive test. Because telithromycin has a potential for severe liver injury, and because the increments of asthma benefit in this study were small, the potential role of TEL in asthma treatment remains to be determined. ■

Comorbid Hypogonadism in Diabetic Men with Erectile Dysfunction

Source: Corona G, et al. *Int J Impot Res.* 2006;18:190-197.

ERECTILE DYSFUNCTION (ED) MOST commonly reflects endothelial dysfunction, usually as a consequence of hypertension, dyslipidemia, smoking, or diabetes. Since diabetic men also have a proclivity to neuropathy (motor, sensory, and autonomic), the combination of vasculopathy with neuropathy is particularly burdensome to erectile function.

In non-diabetic men, hypogonadism is responsible for only a small proportion of ED, typically reported as 5-10%. Recently, an association between diabetes and hypogonadotropic hypogonadism—the situation where both pituitary trophic hormones and testosterone are concomitantly low—has been noted.

A study of consecutive patients attending a sexual dysfunction clinic (n = 1,246) was done which included measurement of LH, TSH, and testosterone (total and free testosterone). Eighteen percent of this population had diabetes. Using the threshold criteria adopted by the authors, the prevalence of hypogonadism in diabetic men was much higher than the non-diabetic men: 24.5% vs 12.6%; *P* < 0.0001. These data also confirmed a disproportionate incidence of hypogonadotropic hypogonadism.

This high prevalence of hypogonadism in diabetic men cannot be extrapolated to the general population of diabetic men

since these subjects were preselected for suffering sexual dysfunction. PDE5 inhibitors have shown lesser efficacy in diabetics than other populations. Comorbid hypogonadism may explain some of this discrepancy. ■

Is Iron Deficiency Related to Alopecia?

Source: Benjamin L, et al. *J Am Acad Dermatol.* 2006;54:824-844.

THE RELATIONSHIP BETWEEN IRON status and hair loss is complex. Most of the data set has evaluated women, who experience iron deficiency anemia 3-5 times more often than men, usually attributable to the combination of lower baseline body stores combined with menstrual blood loss. In trials that have evaluated iron status in women with respect to alopecia, results have been mixed and inconclusive. Some investigators have supplemented iron for women with androgenetic alopecia (in combination with the anti-androgen spironolactone), and found a subgroup of responders.

Despite an the lack of a consensus in the dermatologic literature about the relationship between low iron status and alopecia, these Cleveland Clinic authors screened male and female patients presenting with alopecia with a CBC and serum ferritin, commenting that despite an inconclusive evidence base, their anecdotal experience indicates superior responses in patients with alopecia when depleted iron stores are replenished. When a low ferritin is observed, with or without anemia, the authors provide iron supplementation (dietary or supplement)

to maintain a ferritin concentration greater than 70 ng/mL. Their recommendation includes maintenance of iron treatment for 3-6 months, to ensure replenishment of iron stores. ■

LDL Reduction in Diabetes: Is Much Lower Better?

Source: Shepherd J, et al. *Diabetes Care*. 2006;29:1220-1226.

THE TNT STUDY (TREAT TO NEW Targets) demonstrated that intensive lipid lowering (ILL) with atorvastatin 80 mg/d in patients with stable coronary artery disease (CAD) provided more benefit than simply achieving an LDL of 100 mg/dL with atorvastatin 10 mg/d. This trial provided useful information because it came on the heels of the PROVE-IT trial, which had demonstrated that for persons with acute coronary syndromes, ILL provided greater risk reduction than modest LDL lowering. Whether patients with diabetes in the TNT trial enjoyed similar ben-

efits from ILL had not been previously reported.

There were 1,501 diabetics in TNT. Those on atorvastatin 10 mg achieved a mean LDL of 98.6 mg/dL, compared to an LDL of 77.0 mg/dL for subjects on atorvastatin 80 mg. The lower LDL level was associated with a 25% relative risk reduction for a new primary event, defined as death from coronary heart disease, non-fatal MI, or stroke (103 events vs 135 events). Although all-cause mortality was slightly higher in subjects who received ILL, the difference was not statistically significant. Higher dose atorvastatin was not associated with any safety concerns. ■

What About the Very Elderly and Colonoscopy?

Source: Lin O, et al. *JAMA*. 2006;295:2357-2365.

IN CONTRAST TO GUIDANCE AVAILABLE for clinicians in reference to cessation of screening tools like PAP tests, where there is age-specific direction offered, the current guidelines on screening colonoscopy (sCOL) do not provide any age limit. Colon cancer incidence increases with age, so the yield of screening older persons would be anticipated to be greater than younger individuals. However, at advanced age life expectancy decreases, such that quantifying potential benefits must take age into account.

Lin et al, performed a cross-sectional study (n = 1,244) of sCOL in three groups divided by age: 50-54 years, 75-79 years, and > 80 years. Outcomes of the study included colonic neoplasia detected and gain in life expectancy, with comparisons between age groups.

There was a linear relationship between age and prevalence of neoplasia: 13.8% (age 50-54), 26.5% (age 75-79), and 28.6% (age > 80). Nonetheless, mean gain in life expectancy was substantially lower (6.5-fold lower!) in the oldest age group than the youngest.

Even though sCOL did provide gains in life expectancy, the results were substan-

tially less substantial in the most aged seniors. These data does not provide evidence for any age limit to appropriate use of sCOL. Rather, it may assist in weighing the risk-benefit ratio for sCOL in older persons, depending upon their anticipated life expectancy, individual health issues, and personal preferences. ■

Is There an Iraq War Syndrome? Comparison of the Health of UK Service Personnel after the Gulf and Iraq Wars

Source: Horn O, et al. *Lancet*. 2006;367:1742-1746.

THE SO-CALLED GULF WAR SYNDROME (GWS) is an ill-defined umbrella term to describe the non-specific health complaints registered by armed forces personnel who served in this conflict. Subsequent to the 1991 Gulf War, data from the United States, United Kingdom, Canada, Denmark, and Australia corroborated increases in symptomatic disease, although no clearly-defined syndromic definition evolved. Indeed, it has been opined that the symptoms attributed to the Gulf War may simply be consistent with other issues such as emotional stress and new vaccinations.

Subsequent to the Gulf War, the UK Ministry of Defense funded a project to provide detailed surveillance of health issues for personnel serving in Iraq post the 2003 invasion. In addition to a checklist of the same 50 non-specific symptoms used in GWS screening, they also assessed fatigue (with a validated 13-item scale) and general health (with an item from the SF-36).

In contrast to personnel from the Gulf War, UK personnel in Iraq did not demonstrate any evidence of health effects. It is reassuring to note that heightened surveillance does not detect an "Iraq syndrome." ■

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