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Other:	*None*

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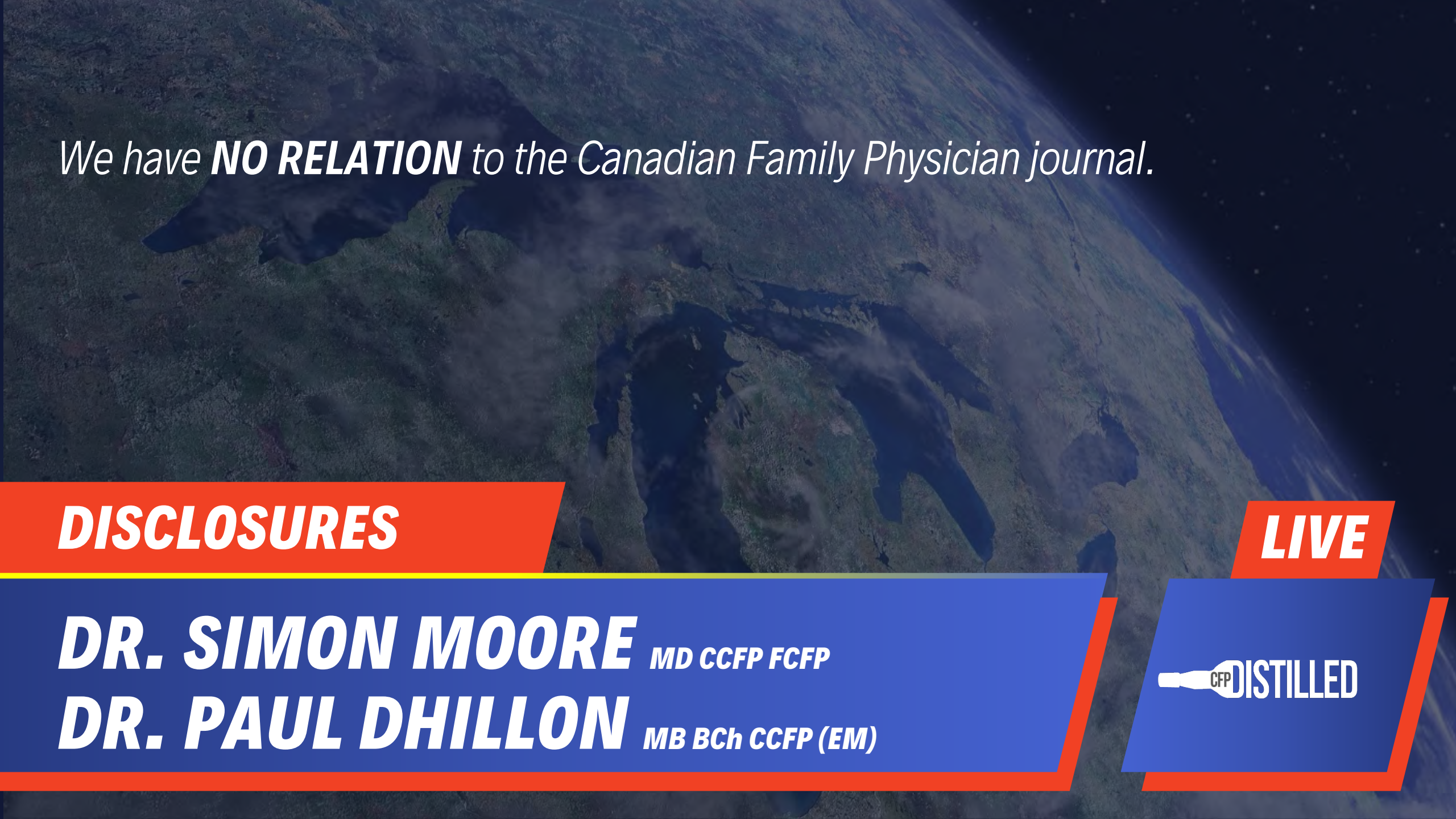

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TRAVEL
TODAY'S SHOW
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TOP ARTICLES IN
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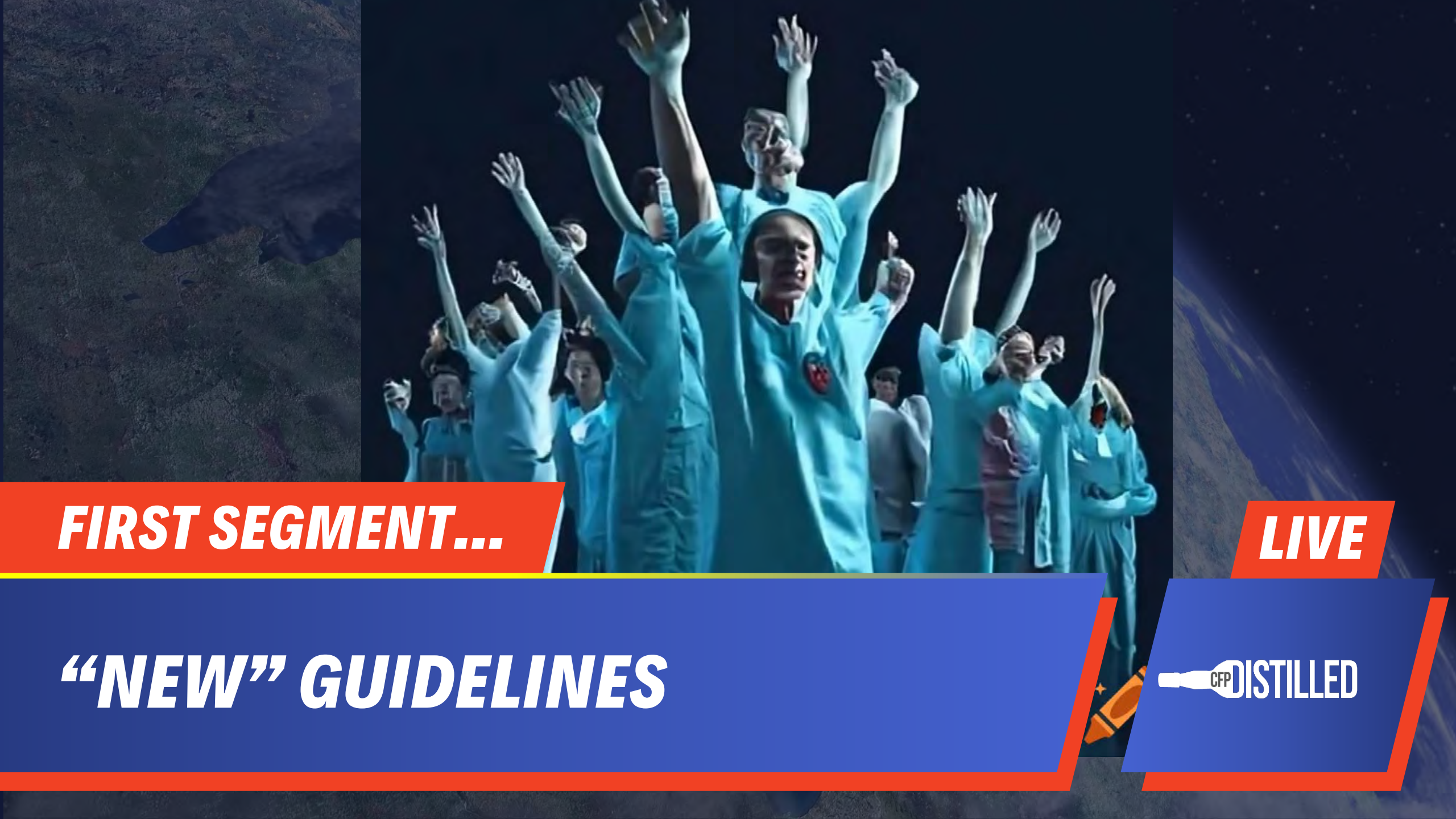
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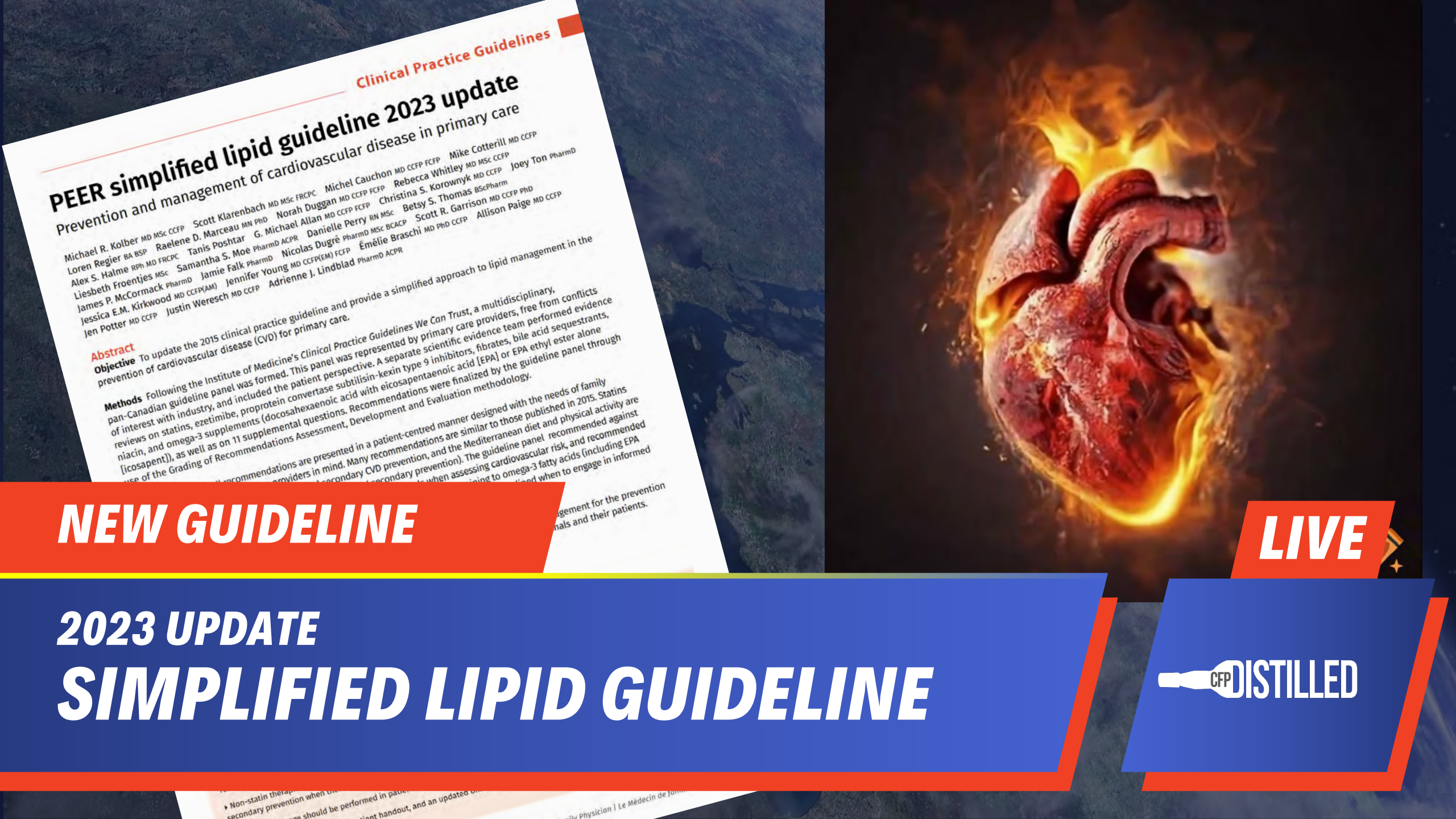
Clinical Practice Guidelines
PEER simplified lipid guideline 2023 update
Prevention and management of cardiovascular disease in primary care
Abstract
NEW GUIDELINE
LIVE
2023 UPDATE
SIMPLIFIED LIPID GUIDELINE
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CFP Oct 2023, 69 (10) 675–686

SAY NO TO...

- Lipid targets
- Fasting
- Annual testing
- apoB and Lp[a]
- Coronary artery calcium scores

UNLIKE THE CCS GUIDELINES

NEW GUIDELINES

LIPIDS

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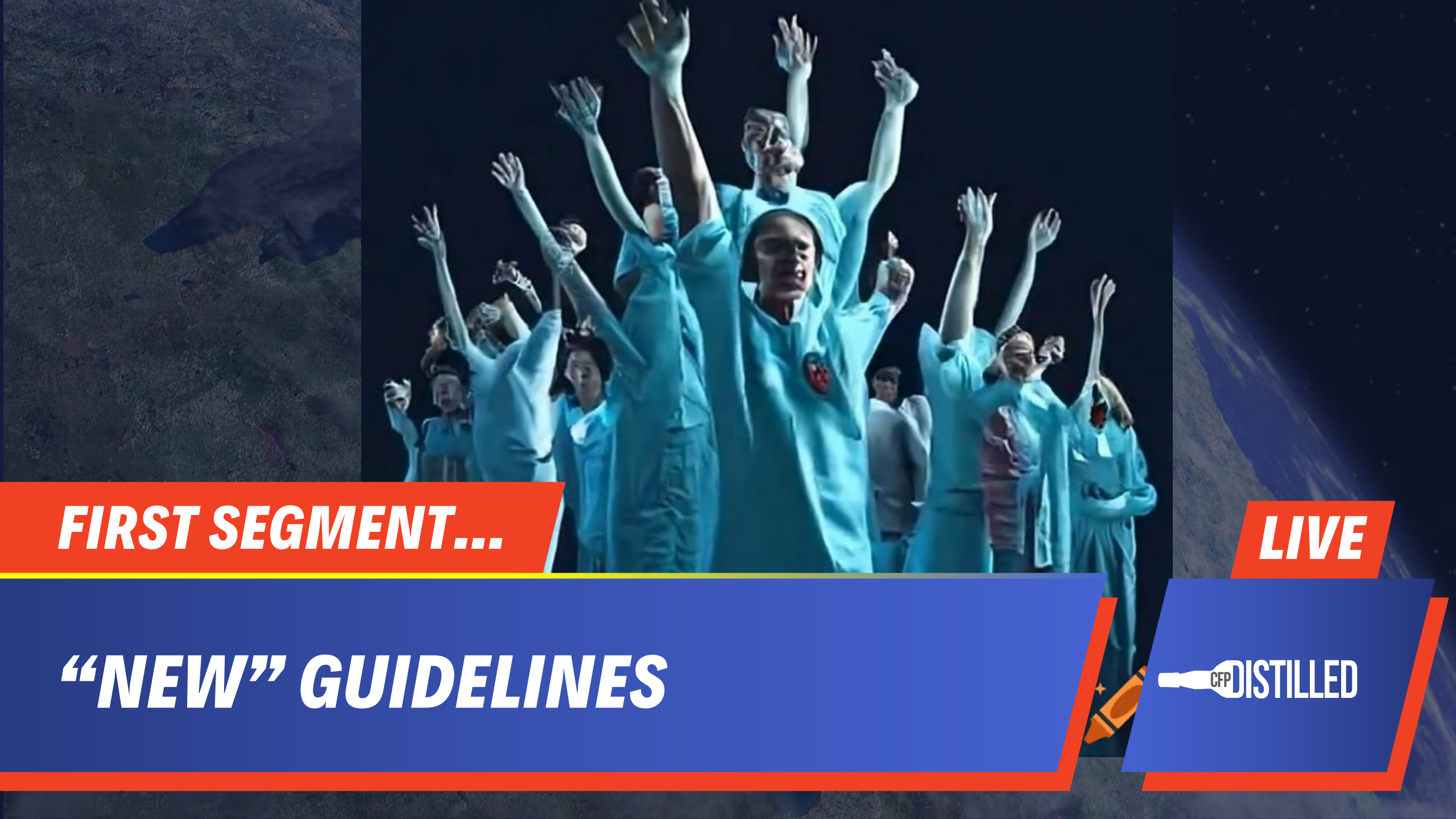
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"NEW" GUIDELINE

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ATRIAL FIBRILLATION 2020 CCS GUIDELINES

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CFP April 2023, 69 (4) 245–256

A. FIB ON 1 SLIDE

- Catch it
- Cause?
- Clot risk?
- Control

GOAL

- ⇩ Symptoms
- ⇧ Quality of life

NEW GUIDELINES

LIVE

ATRIAL FIBRILLATION

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CATCH IT: SCREEN

- *Check pulse in your patients*
- *0.9% detection rate*

NEW GUIDELINES

ATRIAL FIBRILLATION

LIVE

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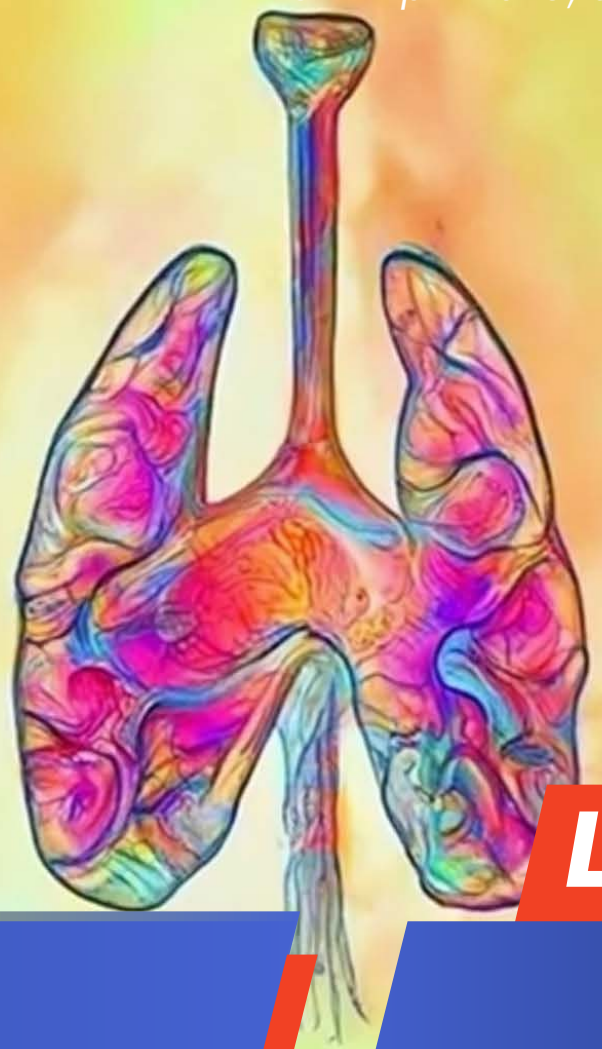
CFP April 2023, 69 (4) 245–256

CAUSE: MODIFIABLE?

- *CVD risks*
- *Thyroid disease*
- *Treat sleep apnea (⇩ A. Fib risk)*



NEW GUIDELINES

ATRIAL FIBRILLATION

LIVE

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CFP April 2023, 69 (4) 245–256

CLOT RISK

- DOACs are now first–line
- NO Antiplatelet agents
- Use CHADS–65 (not CHADS–2)

NEW GUIDELINES

ATRIAL FIBRILLATION

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CFP April 2023, 69 (4) 245–256

CONTROL

- *Rate vs. Rhythm? Still no difference*
- *Early intervention: RHYTHM CONTROL*
  - *⇩ Cardiac death / stroke*

NEW GUIDELINES

ATRIAL FIBRILLATION

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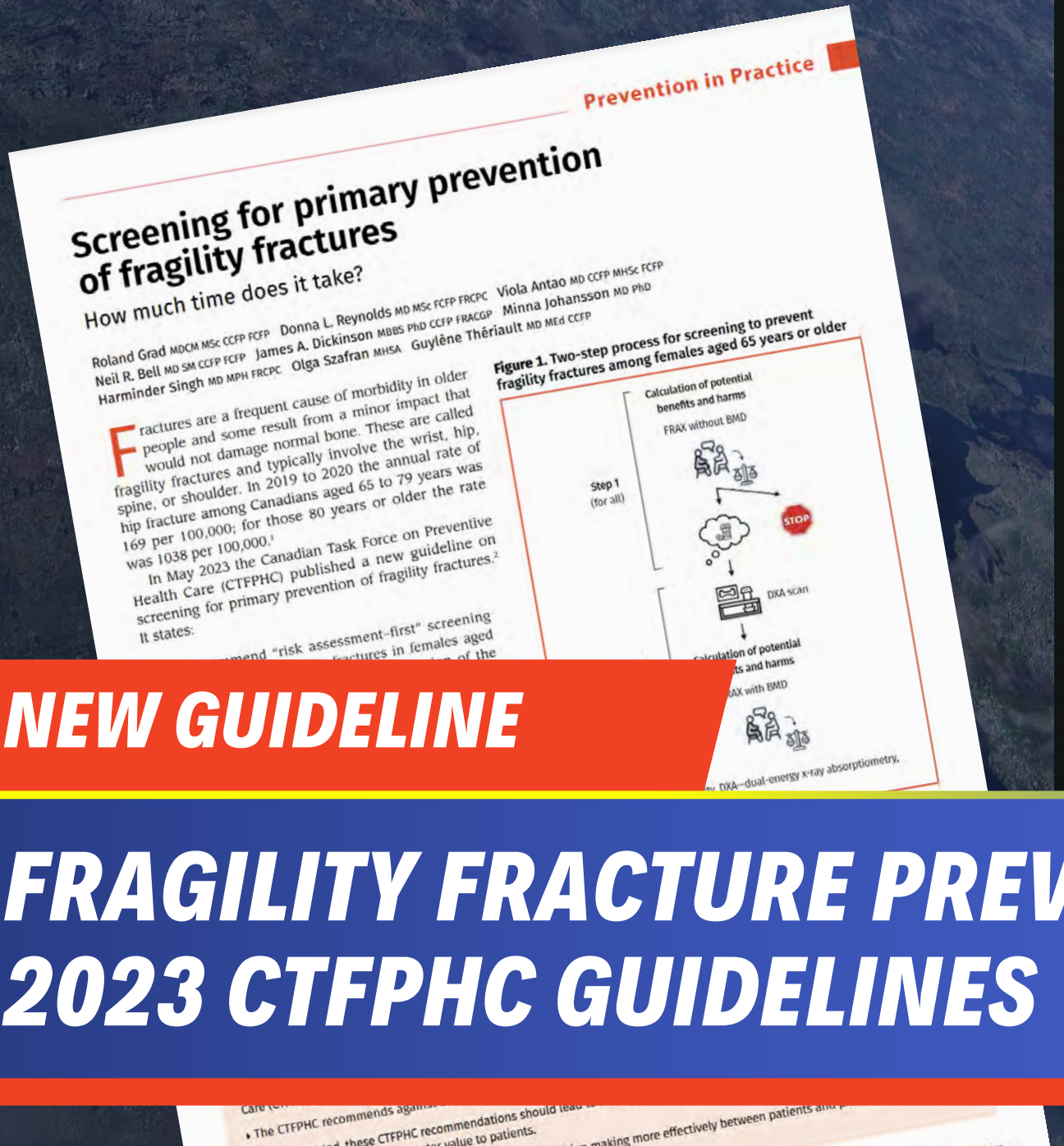
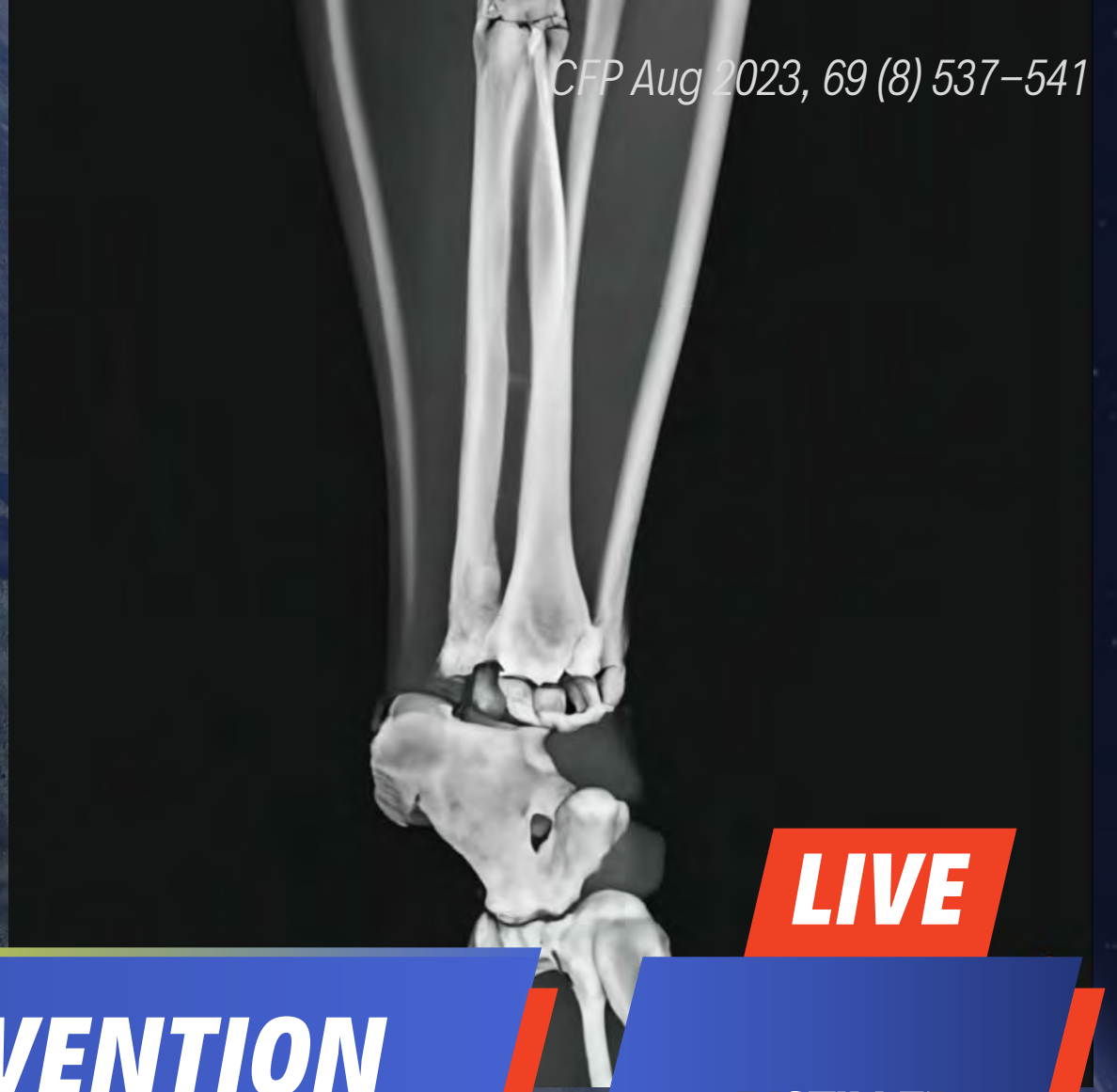
CFP Aug 2023, 69 (8) 537–541





NEW GUIDELINE

FRAGILITY FRACTURE PREVENTION 2023 CTFPHC GUIDELINES

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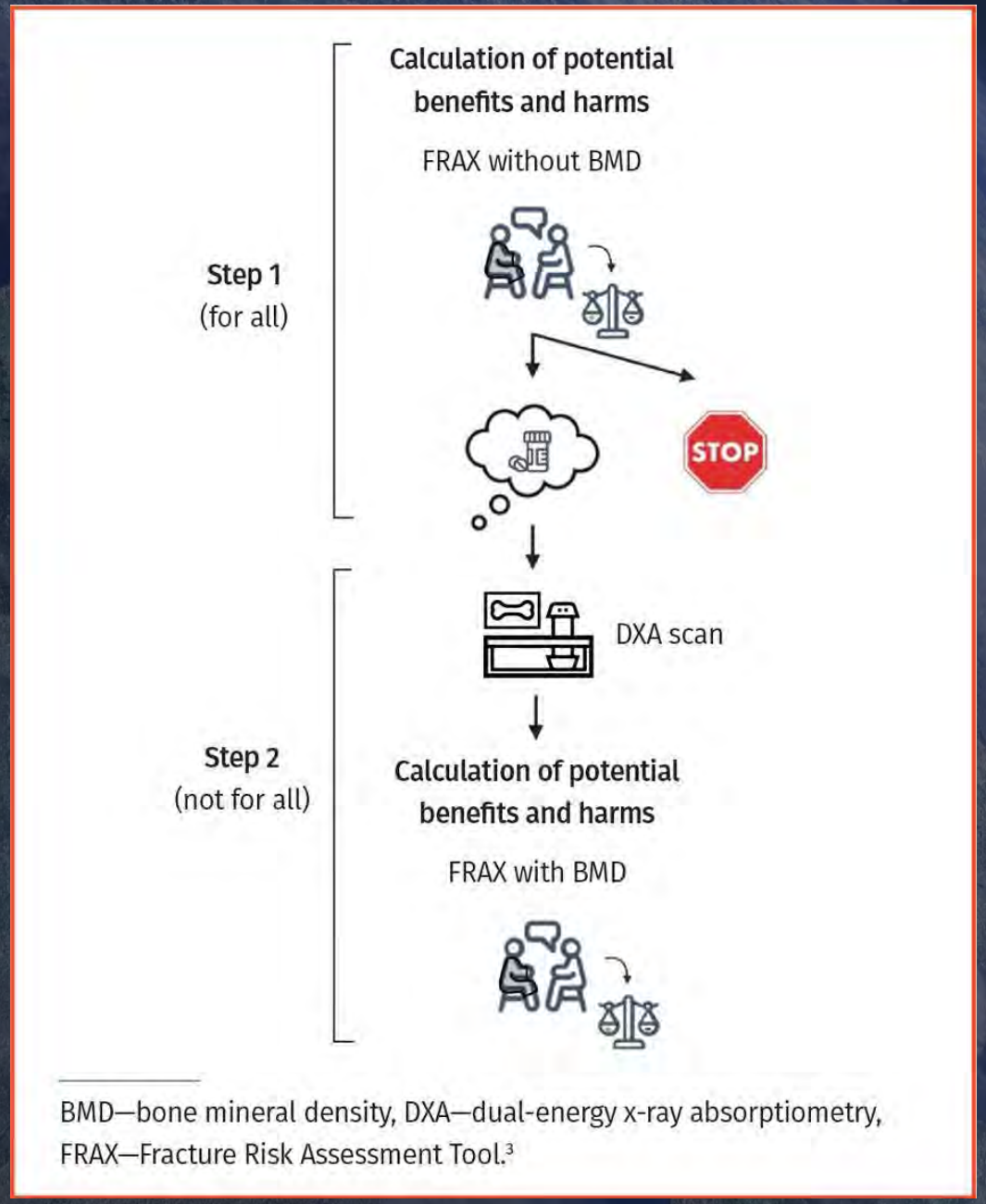

BMD—bone mineral density, DXA—dual-energy x-ray absorptiometry, FRAX—Fracture Risk Assessment Tool.[3]


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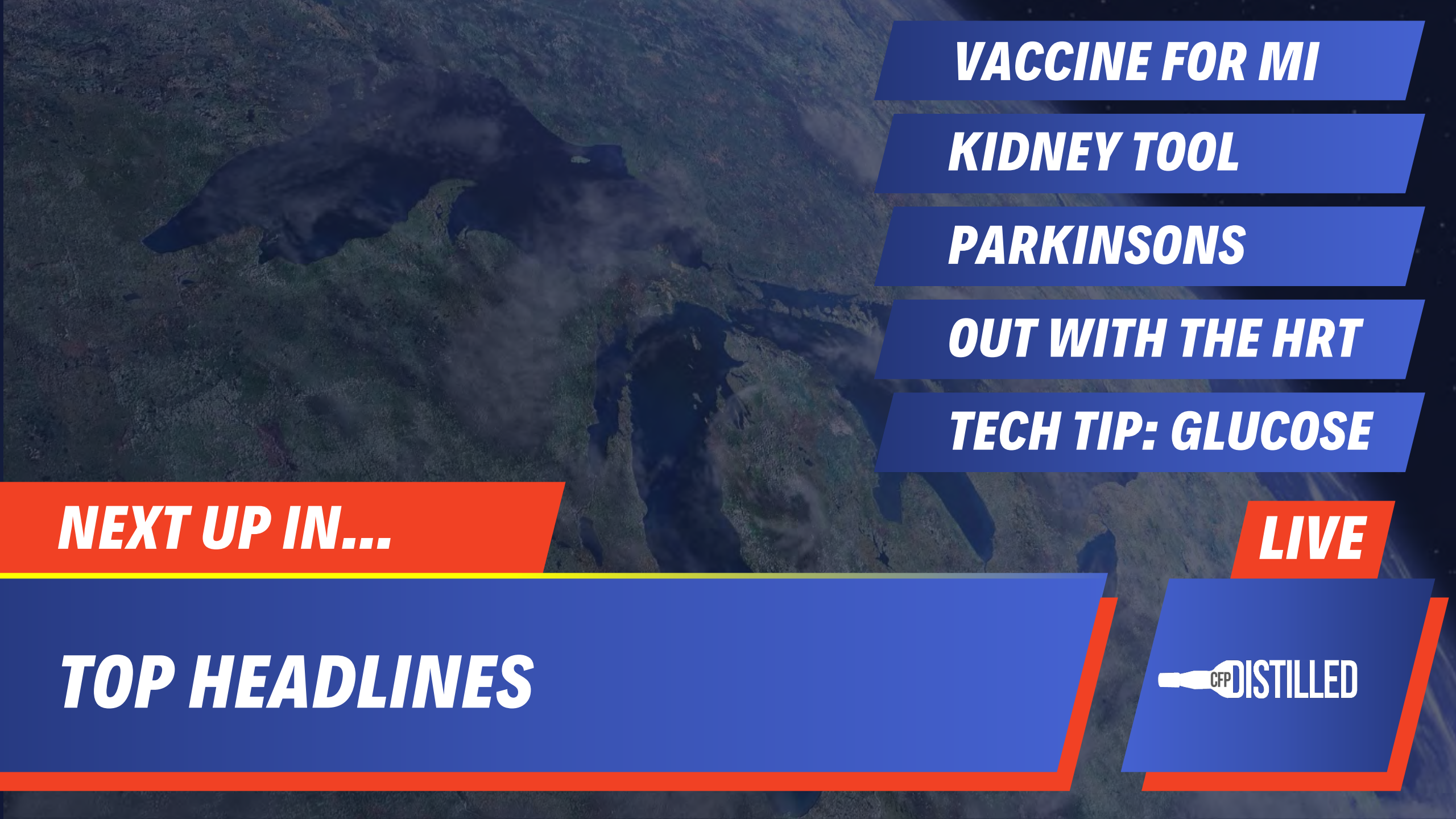
VACCINE FOR MI
KIDNEY TOOL
PARKINSONS
OUT WITH THE HRT
TECH TIP: GLUCOSE
NEXT UP IN...
TOP HEADLINES
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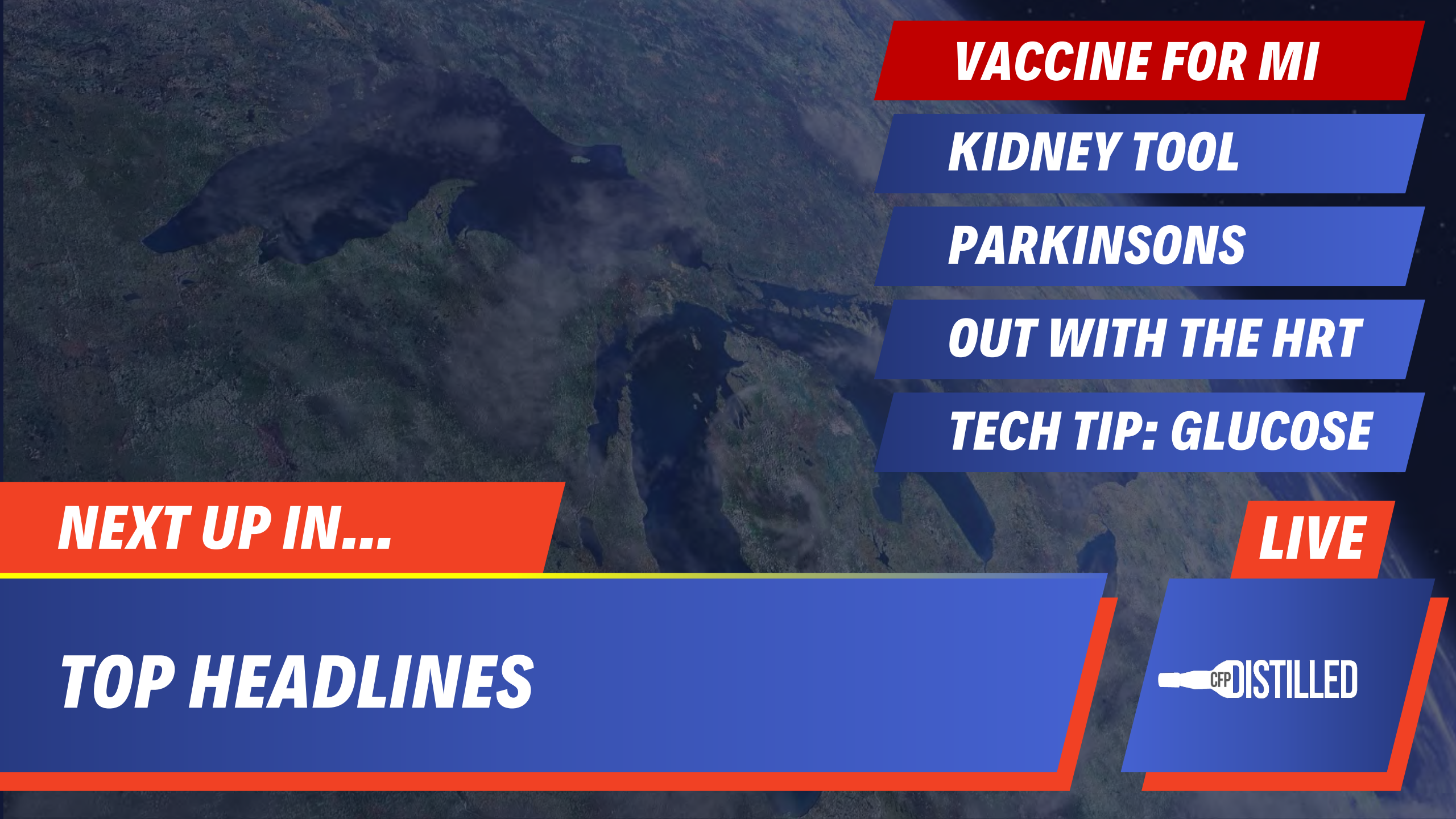
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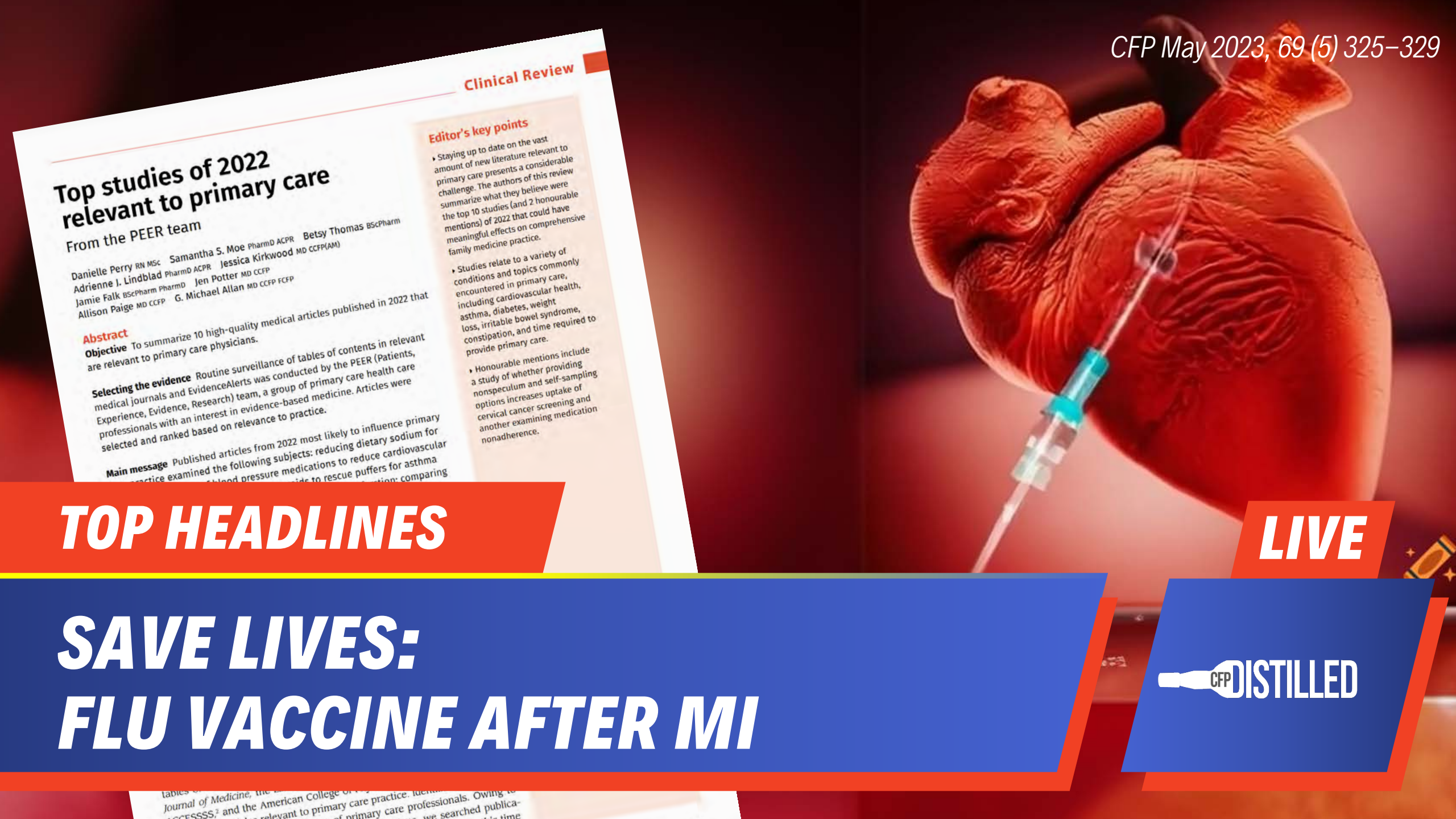
CFP May 2023, 69 (5) 325–329



TOP HEADLINES

SAVE LIVES: FLU VACCINE AFTER MI

LIVE

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CFP May 2023, 69 (5) 325–329

VACCINATE WITHIN 72 HRS

- *Reduces death from 4.9% to 2.9%*
- *NNT = 52 vs. placebo*
- *RCT, double-blind, n=2352*

TOP HEADLINES

LIVE

SAVE LIVES: FLU VACCINE AFTER MI

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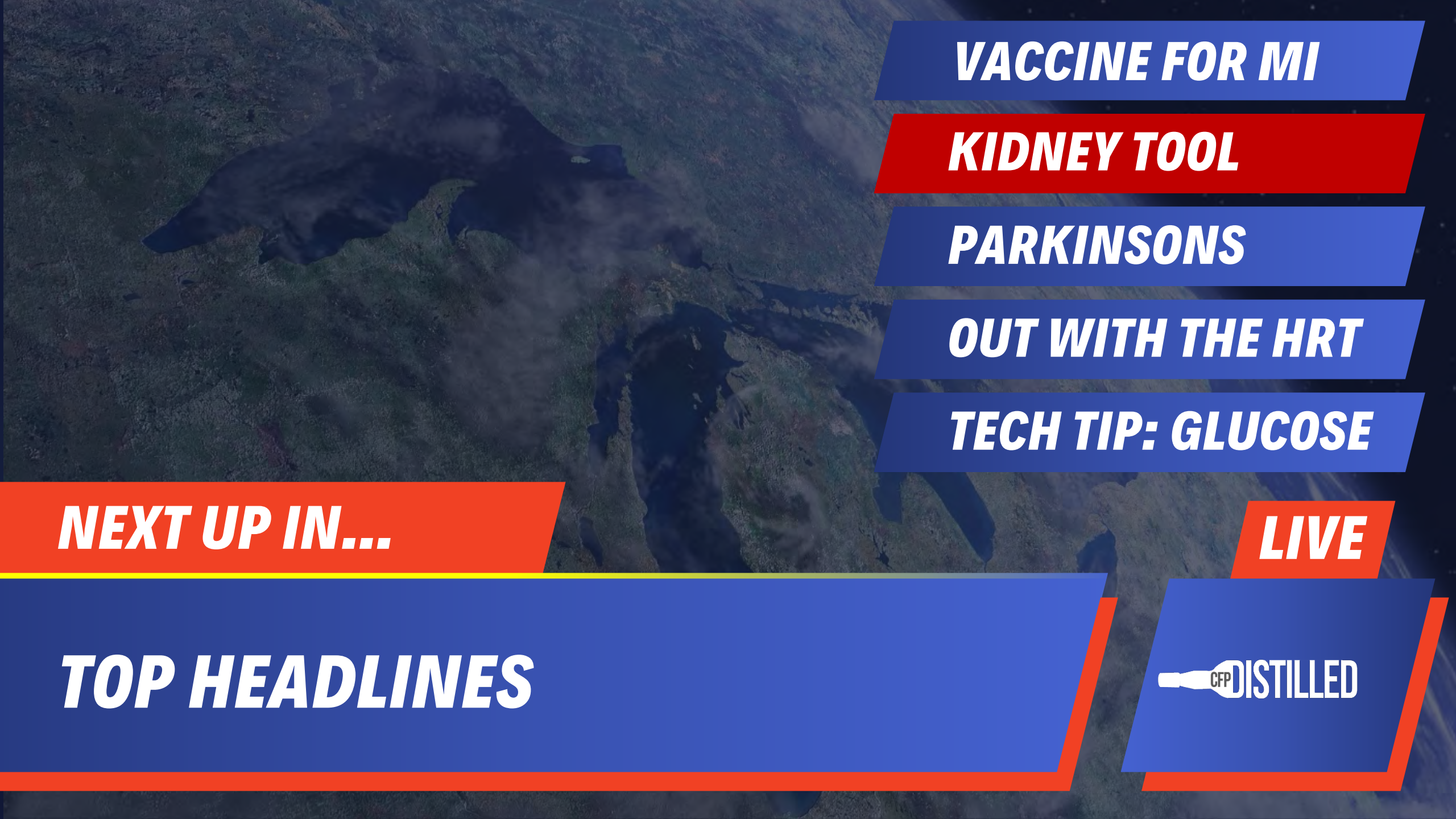
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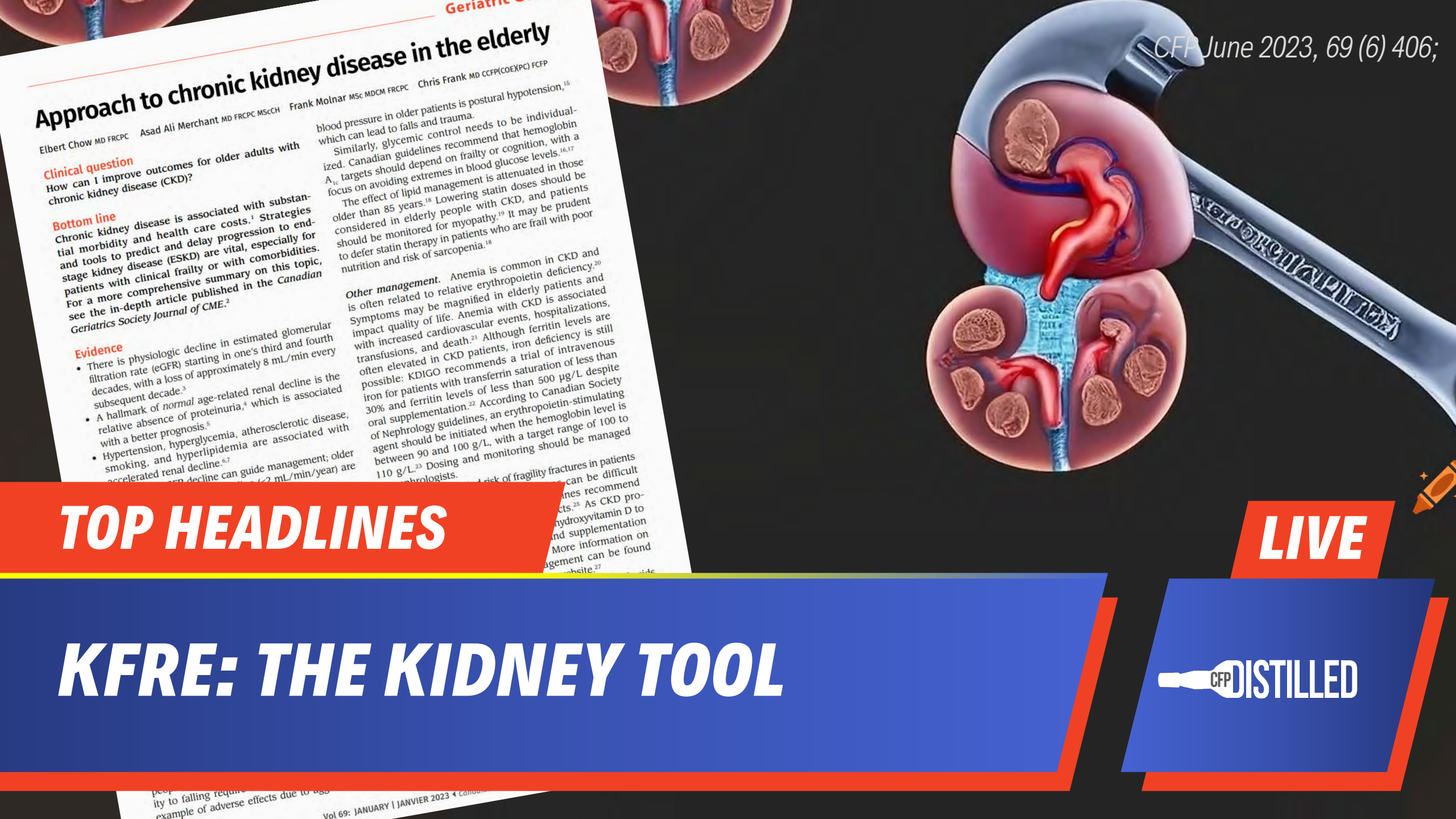

CFP June 2023, 69 (6) 406;

TOP HEADLINES

LIVE

KFRE: THE KIDNEY TOOL

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KIDNEY FAILURE

RISK CALCULATION

If you don't have the information required below talk to your doctor.

Age (Yrs)

Sex

Select

Region

Select

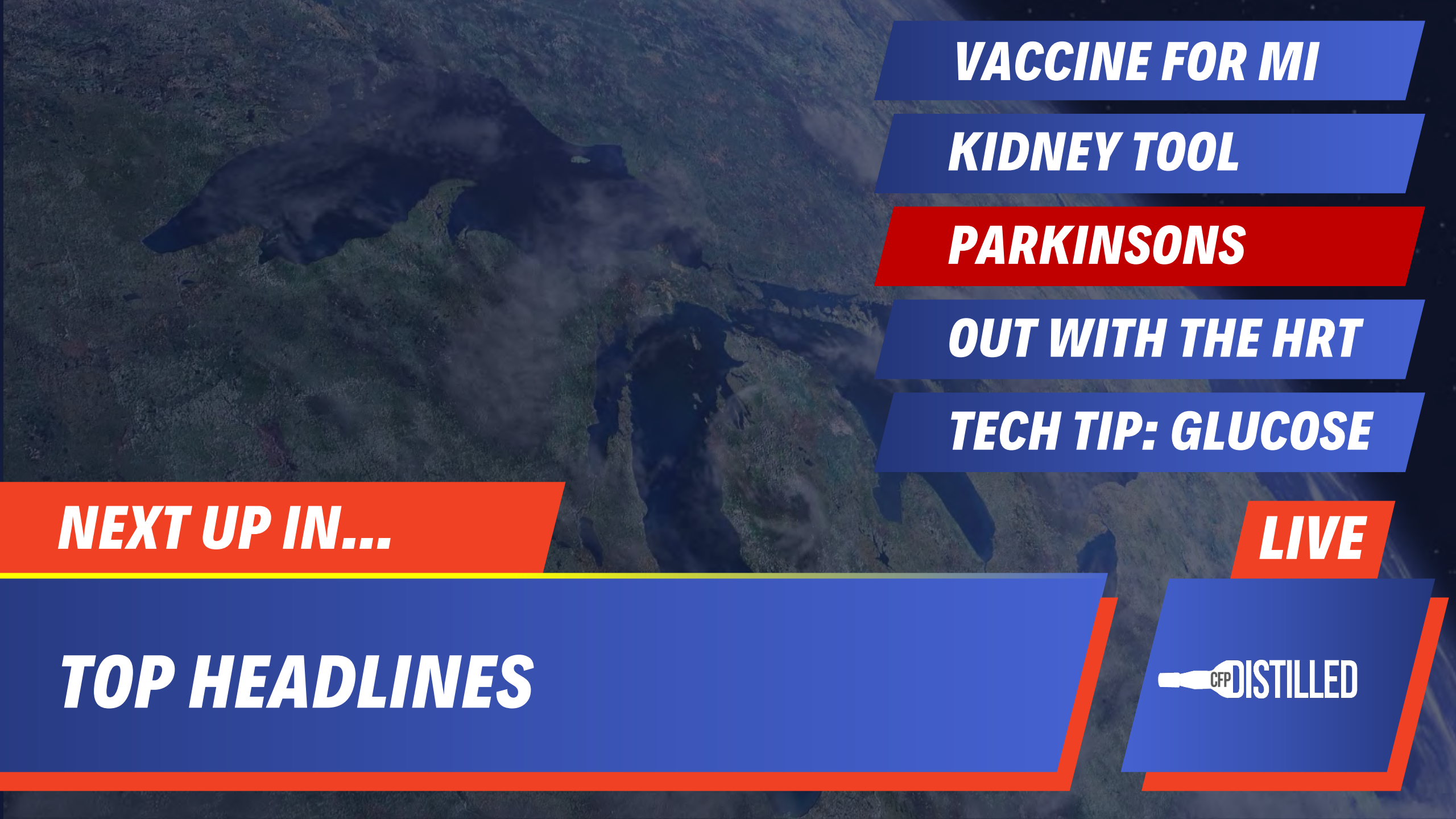
GFR (Ml/Min/1.73M2)

Urine Albumin: Creatinine Ratio

Units

Select

NEXT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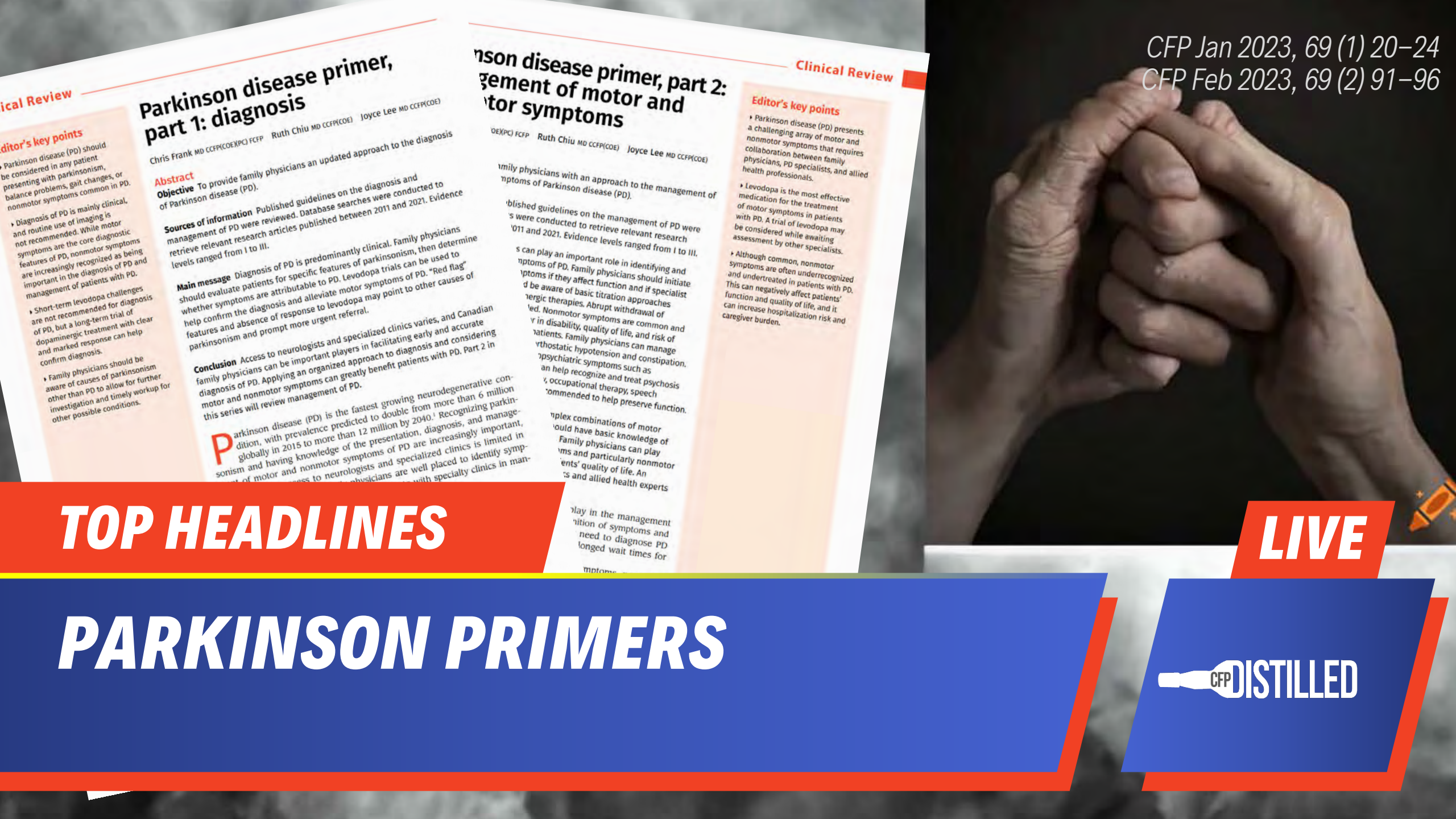
ical Review
ditor's key points
Parkinson disease (PD) should be considered in any patient presenting with parkinsonism, balance problems, gait changes, or nonmotor symptoms common in PD.
Diagnosis of PD is mainly clinical, and routine use of imaging is not recommended. While motor symptoms are the core diagnostic features of PD, nonmotor symptoms are increasingly recognized as being important in the diagnosis of PD and management of patients with PD.
Short-term levodopa challenges are not recommended for diagnosis of PD, but a long-term trial of dopaminergic treatment with clear and marked response can help confirm diagnosis.
Family physicians should be aware of causes of parkinsonism other than PD to allow for further investigation and timely workup for other possible conditions.
Parkinson disease primer, part 1: diagnosis
Chris Frank MD CCFP(COE)(PC) FCFP Ruth Chiu MD CCFP(COE) Joyce Lee MD CCFP(COE)
Abstract
Objective To provide family physicians an updated approach to the diagnosis of Parkinson disease (PD).
Sources of information Published guidelines on the diagnosis and management of PD were reviewed. Database searches were conducted to retrieve relevant research articles published between 2011 and 2021. Evidence levels ranged from I to III.
Main message Diagnosis of PD is predominantly clinical. Family physicians should evaluate patients for specific features of parkinsonism, then determine whether symptoms are attributable to PD. Levodopa trials can be used to help confirm the diagnosis and alleviate motor symptoms of PD. "Red flag" features and absence of response to levodopa may point to other causes of parkinsonism and prompt more urgent referral.
Conclusion Access to neurologists and specialized clinics varies, and Canadian family physicians can be important players in facilitating early and accurate diagnosis of PD. Applying an organized approach to diagnosis and considering motor and nonmotor symptoms can greatly benefit patients with PD. Part 2 in this series will review management of PD.
Parkinson disease (PD) is the fastest growing neurodegenerative condition, with prevalence predicted to double from more than 6 million globally in 2015 to more than 12 million by 2040.[1] Recognizing parkinsonism and having knowledge of the presentation, diagnosis, and manage-
Clinical Review
nson disease primer, part 2: gement of motor and tor symptoms
OE)(PC) FCFP Ruth Chiu MD CCFP(COE) Joyce Lee MD CCFP(COE)
mily physicians with an approach to the management of mptoms of Parkinson disease (PD).
blished guidelines on the management of PD were s were conducted to retrieve relevant research 011 and 2021. Evidence levels ranged from I to III.
s can play an important role in identifying and mptoms of PD. Family physicians should initiate ptoms if they affect function and if specialist d be aware of basic titration approaches nergic therapies. Abrupt withdrawal of ed. Nonmotor symptoms are common and r in disability, quality of life, and risk of atients. Family physicians can manage rthostatic hypotension and constipation. psychiatric symptoms such as an help recognize and treat psychosis , occupational therapy, speech ommended to help preserve function.
plex combinations of motor ould have basic knowledge of Family physicians can play ms and particularly nonmotor ents' quality of life. An s and allied health experts
lay in the management nition of symptoms and need to diagnose PD longed wait times for
Editor's key points
Parkinson disease (PD) presents a challenging array of motor and nonmotor symptoms that requires collaboration between family physicians, PD specialists, and allied health professionals.
Levodopa is the most effective medication for the treatment of motor symptoms in patients with PD. A trial of levodopa may be considered while awaiting assessment by other specialists.
Although common, nonmotor symptoms are often underrecognized and undertreated in patients with PD. This can negatively affect patients' function and quality of life, and it can increase hospitalization risk and caregiver burden.
CFP Jan 2023, 69 (1) 20–24
CFP Feb 2023, 69 (2) 91–96
TOP HEADLINES
PARKINSON PRIMERS
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DIAGNOSIS

1. Find Parkinsonism (Slow, shaky, stiff)
2. Find out cause: Parkinson disease or other?

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PARKINSON PRIMERS

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WHEN TO REFER

- *Falls, vertical gaze palsy – Progressive supranuclear palsy?*
- *History of stroke – Vascular?*
- *Antipsychotic use – Medication–induced?*
- *Early personality change – Tauopathy (e.g. Alzheimer's)?*

TOP HEADLINES

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PARKINSON PRIMERS

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START LEVODOPA & REFER

- *Delay worsens disability*
- *Titrate upwards over 4 weeks*
- *Watch for side effects: nausea, orthostasis, confusion*

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TREAT NON-TREMOR SYMPTOMS

- *Biggest effect on QOL*
- *Constipation, orthostasis, sleep, mood…*
- *Sialorrhea in 70% – Botox, speech language pathology*

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PARKINSON PRIMERS

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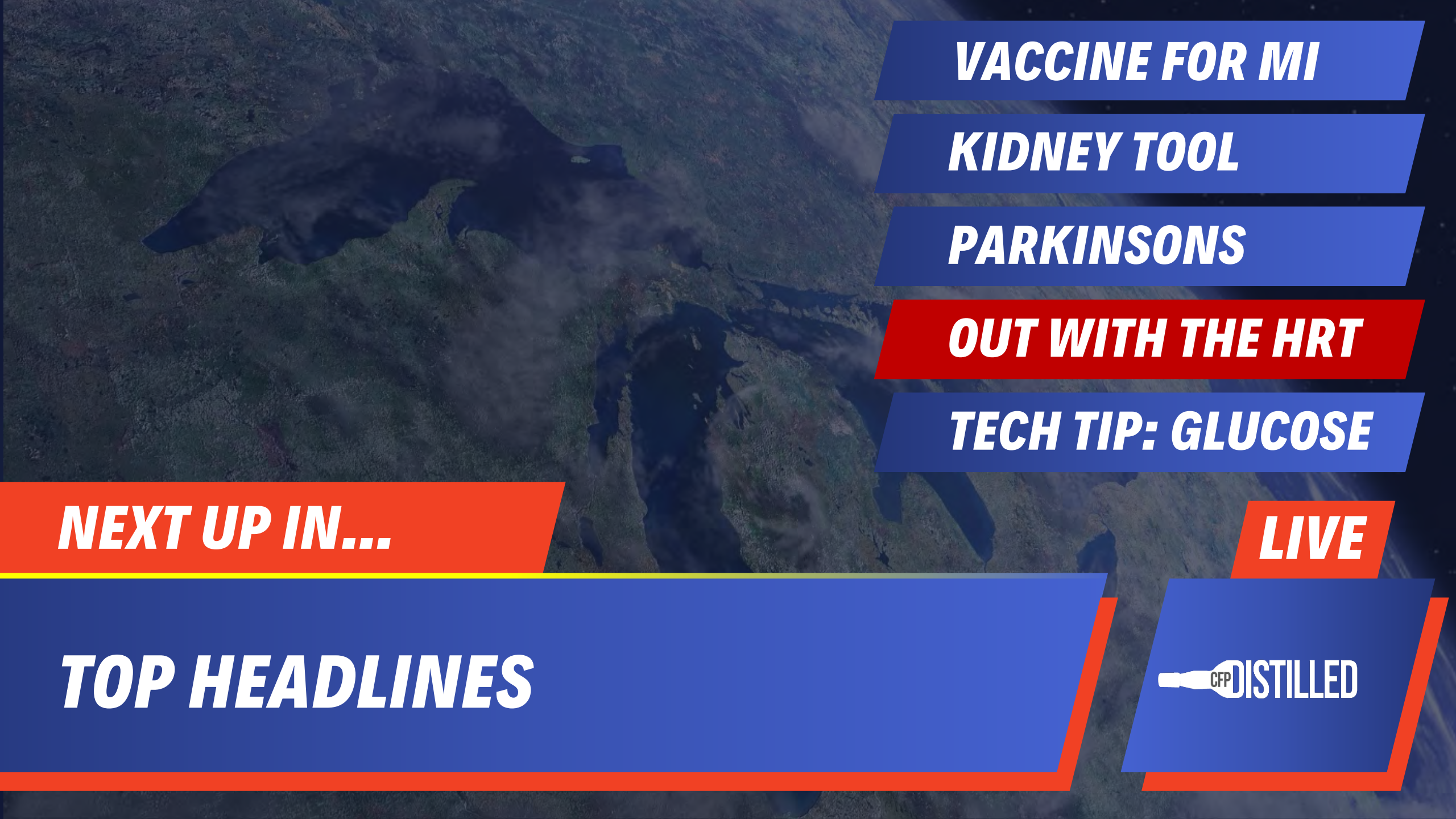
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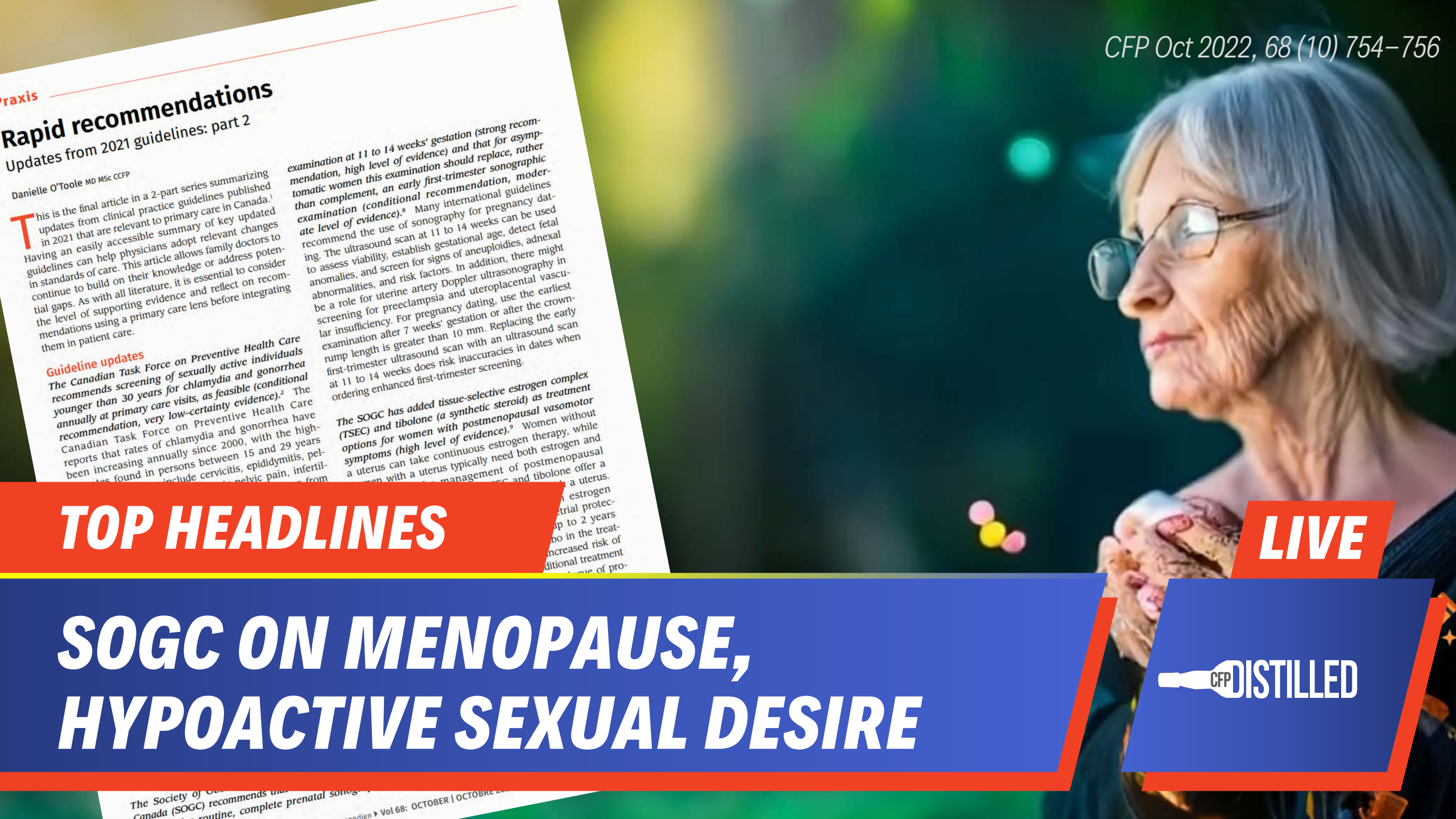

CFP Oct 2022, 68 (10) 754–756

TOP HEADLINES

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SOGC ON MENOPAUSE, HYPOACTIVE SEXUAL DESIRE

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CFP Oct 2022, 68 (10) 754–756

NEW GSM* TREATMENTS

- First line: moisturizers, lubricants
- Second line: vaginal estrogen (even in some breast cancer patients), prasterone, and ospemifene

Formerly atrophic vaginitis, now *genitourinary syndrome of menopause

TOP HEADLINES

LIVE

SOGC ON MENOPAUSE

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NEW HSDD* TREATMENTS

- *Educate: menopause, aging, foreplay, and nonpenetrative alternatives*
- *Premenopause: Flibanserin*
- *Post–menopause: Flibanserin or testosterone patches (off–label)*

Strong recommendation, moderate level of evidence

TOP HEADLINES

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SOGC ON *HYPOACTIVE SEXUAL DESIRE DISORDER

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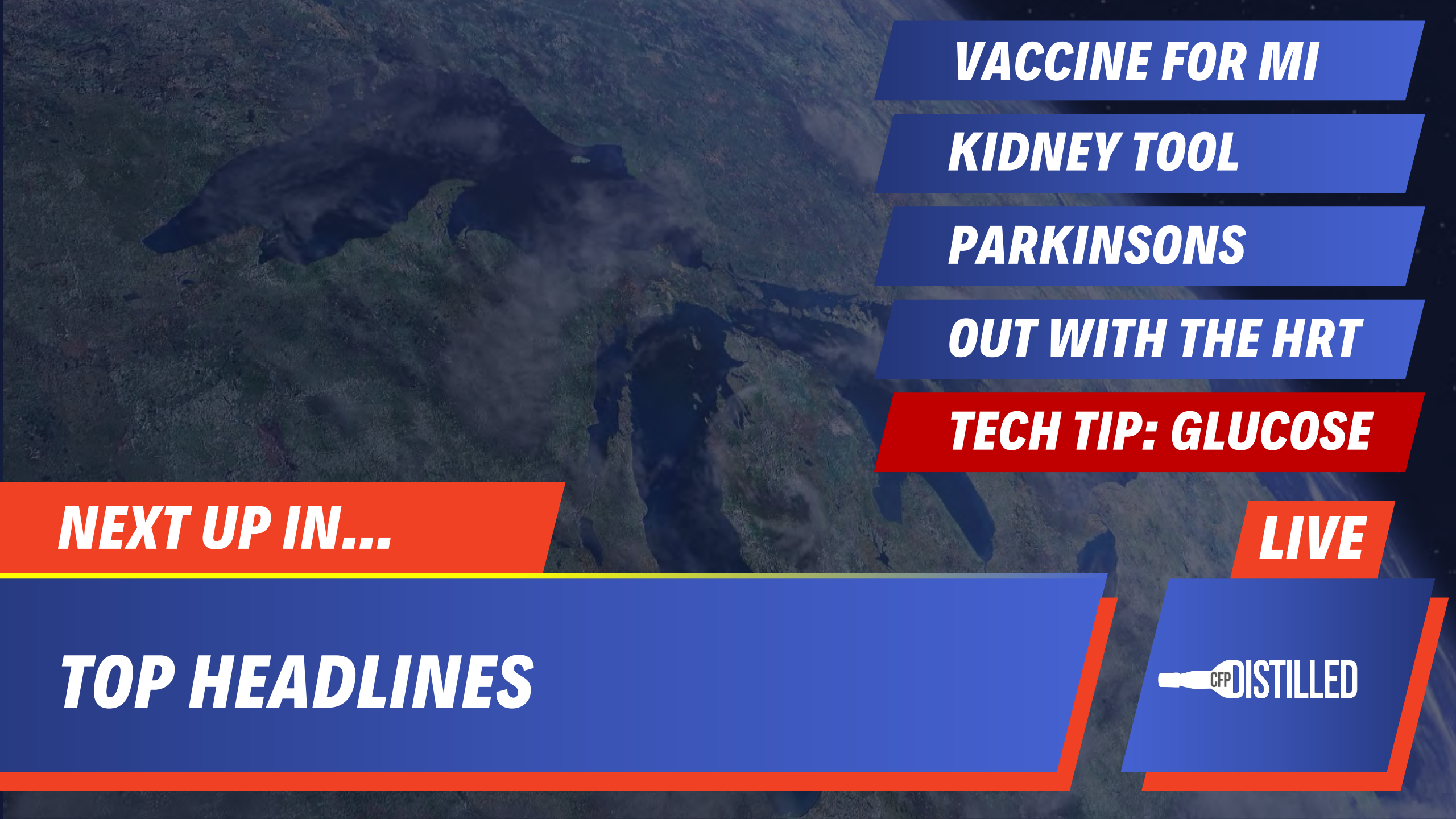
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Tools for Practice

Continuous glucose monitoring in diabetes

Samantha S. Moe PharmD ACPR Michael R. Kolber MD CCFP MSc FCFP Jamie Falk PharmD

Clinical question

Compared with self-monitoring blood glucose (SMBG), does continuous glucose monitoring improve clinical outcomes or hemoglobin A_{1c} (HbA_{1c}) levels for adults with diabetes taking insulin?

Bottom line

Continuous glucose monitors use subcutaneous sensors and include real-time monitors (RTMs) and flash monitors (FMs). In patients with type 1 diabetes, RTM use is associated with lower rates of severe hypoglycemic events (6%) compared with SMBG use (8%), with no reported events in those with type 2 diabetes. Effects on HbA_{1c} may not be clinically meaningful. Compared with SMBG, FMs do not differ regarding rates of severe hypoglycemic events, and effects on HbA_{1c} are inconsistent (type 1) or similar (type 2). Cost may limit use.

Evidence

Results were statistically different unless indicated. A minimal clinically important HbA_{1c} change was defined as 0.5%.[1]

- Type 1 diabetes, RTMs vs SMBG (8 systematic reviews; 11 to 22 RCTs; 1399 to 2461 patients): At 4 to 12 months, the percentage of severe hypoglyce- ... requiring third-party assistance (3 system- ... substantial methodologic flaws[1-3]) ... 6% to 10% SMBG,

- Limitations: Most RCTs were unblinded and industry funded. Quality-of-life scores were inconsistently reported.

Context

- Real-time monitors automatically display readings (eg, Dexcom 6) whereas FMs require manual upload (eg, FreeStyle Libre). Replace sensors every 7 to 14 days.[9]
- Cost per year: approximately $2500 to $6000 vs $1200 for 4-times daily SMBG.[9]

Implementation

New diabetes guidelines emphasize the use of medications with proven cardiorenal benefit in patients at high risk, with glycemic control a secondary focus.[10] Exercise, healthy dietary choices, and medication adherence should continue to be encouraged. Advising non-insulin dependent patients to check glucose readings frequently is likely unnecessary. Continuous glucose monitor readings may lag behind SMBG by up to 15 minutes, particularly after exercising or eating.[11]

Dr Samantha S. Moe is Clinical Evidence Expert at the College of Family Physicians of Canada. Dr Michael R. Kolber is Professor in the Department of Family Medicine at the University of Alberta in Edmonton. Dr Jamie Falk is a pharmacist and Associate Professor in the College of Pharmacy at the University of Manitoba in Winnipeg.

Competing interests

None declared

References

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2. Wang Y, Zou C, Na H, Zeng W, Li X. Effect of different glucose monitoring methods on bold glucose control: a systematic review and meta-analysis. Comput Math Methods Med 2022;2022:2851572.
3. Teo E, Hassan N, Tam W, Koh S. Effectiveness of continuous glucose monitoring in maintaining glycaemic control among people with type 1 diabetes mellitus: a systematic review of randomised ... Diabetologia 2022;65(4):604-19. Epub 2022 Feb 9.

CFP June 2023, 69 (6) 406

TOP HEADLINES

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CONTINUOU$$$ GLUCO$$$E MONITOR$$$

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CFP June 2023, 69 (6) 406

Type 1

- *Severe hypoglycemia: 6% with real–time monitoring (vs 8% with self–monitoring)*
- *A1c: similar*

Type 2

- *Hypoglycemia: No difference*
- *A1c: No difference*

TOP HEADLINES

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CONTINUOU$$$ GLUCO$$$E MONITOR$$$

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NEXT SEGMENT...
LIVE
THE CFP:DISTILLED KITCHEN
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PYOGENIC SALT
MALNOURISHMENT
Ω 3
CONTRACEPTION
NEW INGREDIENT
NEXT UP IN...
COOKING
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PYOGENIC SALT
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CFP July 2023, 69 (7) 479–480


Praxis

Simple, safe, and effective treatment for pyogenic granuloma

Edward S. Weiss MD CCFP DipPDerm Dominic Wood BSc

Pyogenic granuloma (PG) is a relatively common cutaneous condition often seen by family physicians. Patients frequently seek treatment for PG owing to the friable nature of the lesion and resultant nuisance bleeding from minor trauma. It is generally easy to diagnose, as the clinical appearance is fairly typical: a fleshy, ulcerated, reddish papule that grows quickly over the course of weeks to months.[1] Pyogenic granuloma has numerous treatment options, including surgical excision, curettage and electrocautery, and vascular laser, although risk of recurrence is not insubstantial.[1] The differential diagnosis for a lesion resembling PG includes rare cases of amelanotic melanoma, and for this reason it is sometimes recommended that ablative treatments (eg, cryotherapy) be avoided—unless the lesion can be demonstrated to be benign by histologic examination.

Busy clinicians may wish to have a simple method for correctly diagnosing and treating benign PG. Thankfully, there is a quick and easy way to do so, using the most common of household ingredients: table salt. Long recognized for its utility in treating umbilical granulomas, salt application has also been shown to be safe, effective, and well-tolerated for treatment of PG.[2] It is believed that salt acts as a desiccant, causing shrinkage of the small vessels feeding the PG. An amelanotic mel- expected to regress substantially in

Figure 1A. Step 1 in creating a makeshift salt reservoir to treat pyogenic granuloma: *Prepare a piece of tape with a medial slit.*

Figure 1B. Step 2 in creating a makeshift salt reservoir to treat pyogenic granuloma: *Allow the edges of the slit to overlap slightly, creating a reservoir for table salt.*

...ir to treat ...the lesion.

COOKING

LIVE

SALTY TREATMENT FOR PYOGENIC GRANULOMA

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PYOGENIC SALT
MALNOURISHMENT
Ω 3
CONTRACEPTION
NEW INGREDIENT
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COOKING
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Case Report
Malnourishment masquerading as dementia
Inadequate social support associated with cognitive impairment
Kwame Agyei BSc Donald F. Weaver MD PhD FRCPC
Editor's key points
Points de repère du rédacteur
CFP Feb 2023, 69 (2) 103–105
COOKING
LIVE
MALNOURISHMENT MASQUERADE
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CFP Feb 2023, 69 (2) 103–105

CASE REPORT

- 92 F with dementia MMSE 24/30
- 3 months after moving to long–term care, MMSE = 29/30
- Her diet had been cookies, chips, tea

LIVE

DEMENTIA OR MALNOURISHMENT?

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PYOGENIC SALT
MALNOURISHMENT
Ω 3
CONTRACEPTION
NEW INGREDIENT
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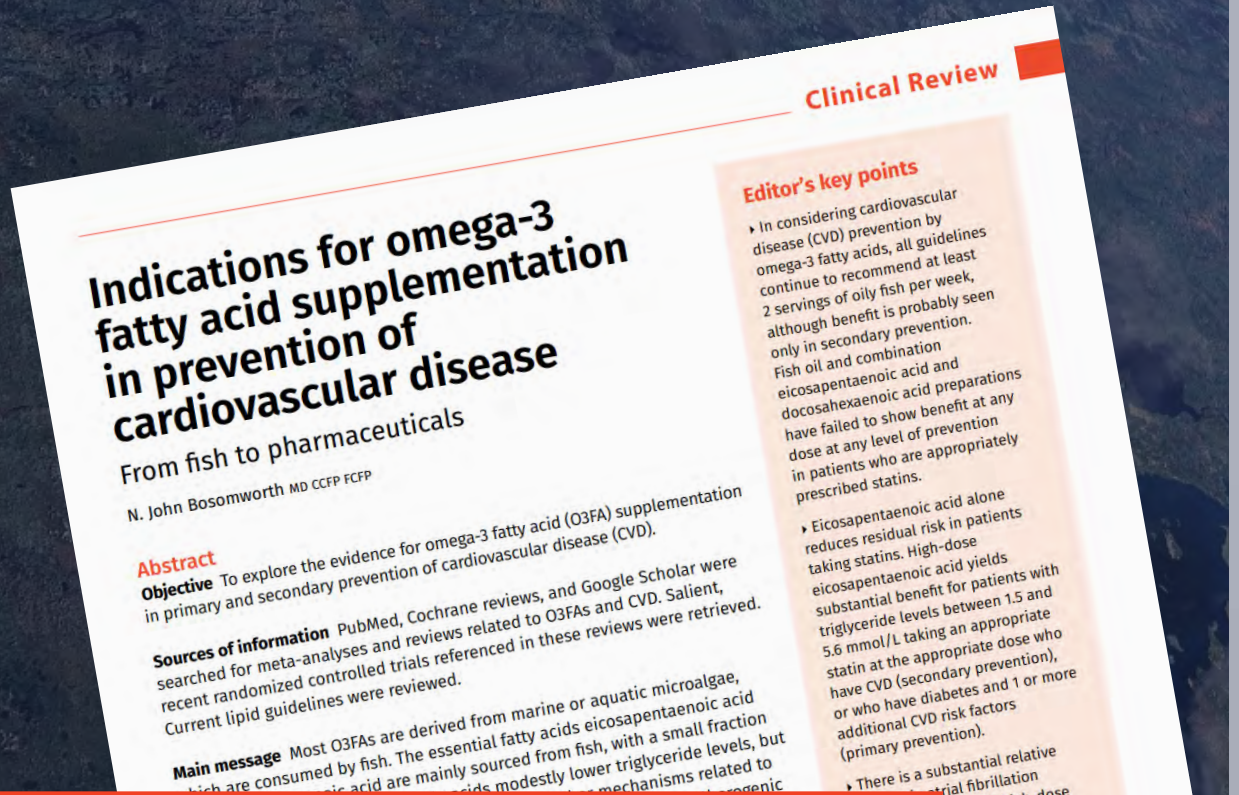
Clinical Review

Indications for omega-3 fatty acid supplementation in prevention of cardiovascular disease

From fish to pharmaceuticals

N. John Bosomworth MD CCFP FCFP

Abstract

Objective To explore the evidence for omega-3 fatty acid (O3FA) supplementation in primary and secondary prevention of cardiovascular disease (CVD).

Sources of information PubMed, Cochrane reviews, and Google Scholar were searched for meta-analyses and reviews related to O3FAs and CVD. Salient, recent randomized controlled trials referenced in these reviews were retrieved. Current lipid guidelines were reviewed.

Main message Most O3FAs are derived from marine or aquatic microalgae, which are consumed by fish. The essential fatty acids eicosapentaenoic acid and docosahexaenoic acid are mainly sourced from fish, with a small fraction of alpha-linolenic acid sourced from plants. O3FAs modestly lower triglyceride levels, but the cardioprotective mechanisms related to

Editor's key points

- In considering cardiovascular disease (CVD) prevention by omega-3 fatty acids, all guidelines continue to recommend at least 2 servings of oily fish per week, although benefit is probably seen only in secondary prevention. Fish oil and combination eicosapentaenoic acid and docosahexaenoic acid preparations have failed to show benefit at any dose at any level of prevention in patients who are appropriately prescribed statins.
- Eicosapentaenoic acid alone reduces residual risk in patients taking statins. High-dose eicosapentaenoic acid yields substantial benefit for patients with triglyceride levels between 1.5 and 5.6 mmol/L taking an appropriate statin at the appropriate dose who have CVD (secondary prevention), or who have diabetes and 1 or more additional CVD risk factors (primary prevention).
- There is a substantial relative ...trial fibrillation ...th use of high-dose ...tty acids, but the ...ncrease is small. No ...n of harm is found at doses ... g per day.

acid shows substan... high triglyceride levels.

...ers first evolved as hunter-gatherers a... ...million years ago.[1] In compari- ...ore mono- and

COOKING

LIVE

Ω 3 INDICATIONS

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CFP July 2023, 69 (7) 459–468

CARDIOVASCULAR BENEFIT?

- *Evidence only supports secondary prevention*
- *No benefit over statin*
- *Guidelines: eat 2 servings oily fish / week*

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Ω 3 INDICATIONS


PYOGENIC SALT
MALNOURISHMENT
Ω 3
CONTRACEPTION
NEW INGREDIENT
NEXT UP IN...
COOKING
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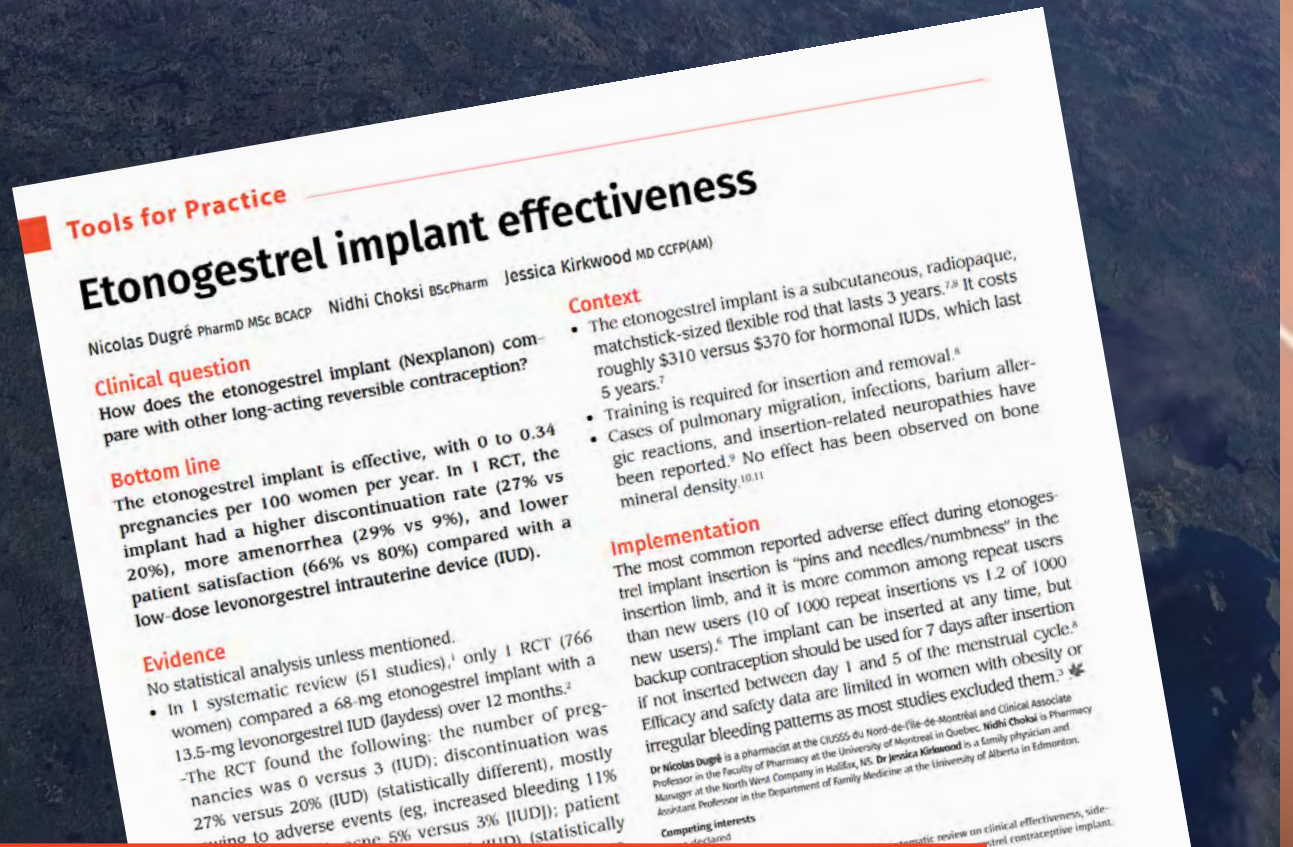
CFP Aug 2022, 68 (8) 594



Tools for Practice

Etonogestrel implant effectiveness

Nicolas Dugré PharmD MSc BCACP Nidhi Choksi BScPharm Jessica Kirkwood MD CCFP(AM)

Clinical question

How does the etonogestrel implant (Nexplanon) compare with other long-acting reversible contraception?

Bottom line

The etonogestrel implant is effective, with 0 to 0.34 pregnancies per 100 women per year. In 1 RCT, the implant had a higher discontinuation rate (27% vs 20%), more amenorrhea (29% vs 9%), and lower patient satisfaction (66% vs 80%) compared with a low-dose levonorgestrel intrauterine device (IUD).

Evidence

No statistical analysis unless mentioned.

- In 1 systematic review (51 studies),[1] only 1 RCT (766 women) compared a 68-mg etonogestrel implant with a 13.5-mg levonorgestrel IUD (Jaydess) over 12 months.[2]
- The RCT found the following: the number of pregnancies was 0 versus 3 (IUD); discontinuation was 27% versus 20% (IUD) (statistically different), mostly owing to adverse events (eg, increased bleeding 11% [IUD]); pain 5% versus 3% [IUD]); patient
- Similar efficacy
tions[6] were found in observation

Context

- The etonogestrel implant is a subcutaneous, radiopaque, matchstick-sized flexible rod that lasts 3 years.[7,8] It costs roughly $310 versus $370 for hormonal IUDs, which last 5 years.[7]
- Training is required for insertion and removal.[8]
- Cases of pulmonary migration, infections, barium allergic reactions, and insertion-related neuropathies have been reported.[9] No effect has been observed on bone mineral density.[10,11]

Implementation

The most common reported adverse effect during etonogestrel implant insertion is "pins and needles/numbness" in the insertion limb, and it is more common among repeat users than new users (10 of 1000 repeat insertions vs 1.2 of 1000 new users).[6] The implant can be inserted at any time, but backup contraception should be used for 7 days after insertion if not inserted between day 1 and 5 of the menstrual cycle.[8] Efficacy and safety data are limited in women with obesity or irregular bleeding patterns as most studies excluded them.[3]

Dr Nicolas Dugré is a pharmacist at the CIUSSS du Nord-de-l'Île-de-Montréal and Clinical Associate Professor in the Faculty of Pharmacy at the University of Montreal in Quebec. **Nidhi Choksi** is Pharmacy Manager at the North West Company in Halifax, NS. **Dr Jessica Kirkwood** is a family physician and Assistant Professor in the Department of Family Medicine at the University of Alberta in Edmonton.

Competing interests

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CONTRACEPTIVE IMPLANT

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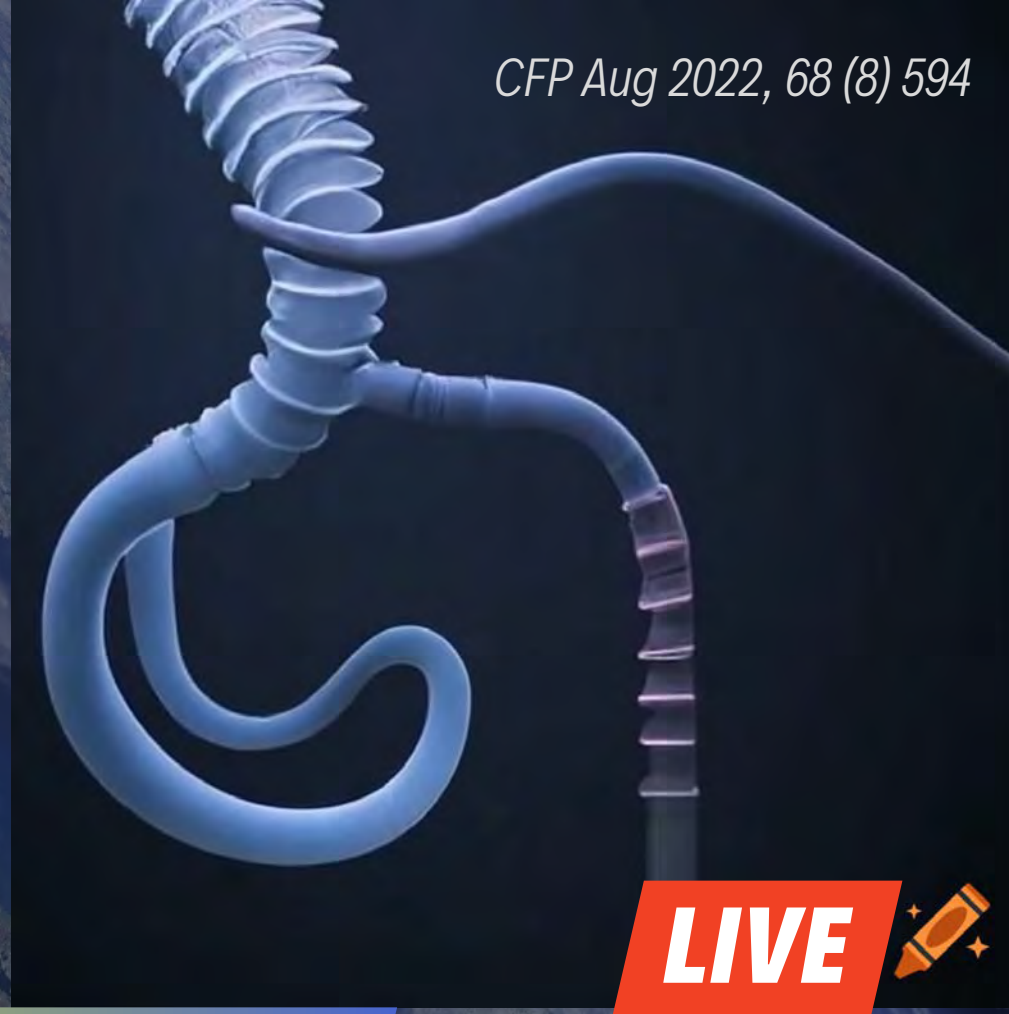
IMPLANT ($310) vs. LOW-DOSE IUS ($370)

- More discontinuation (27 vs 20%)
- More amenorrhea (29% vs 9%)
- Less patient satisfaction (66% vs 80%)



CFP Aug 2022, 68 (8) 594

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PROS AND CON(TRACEPTION)S

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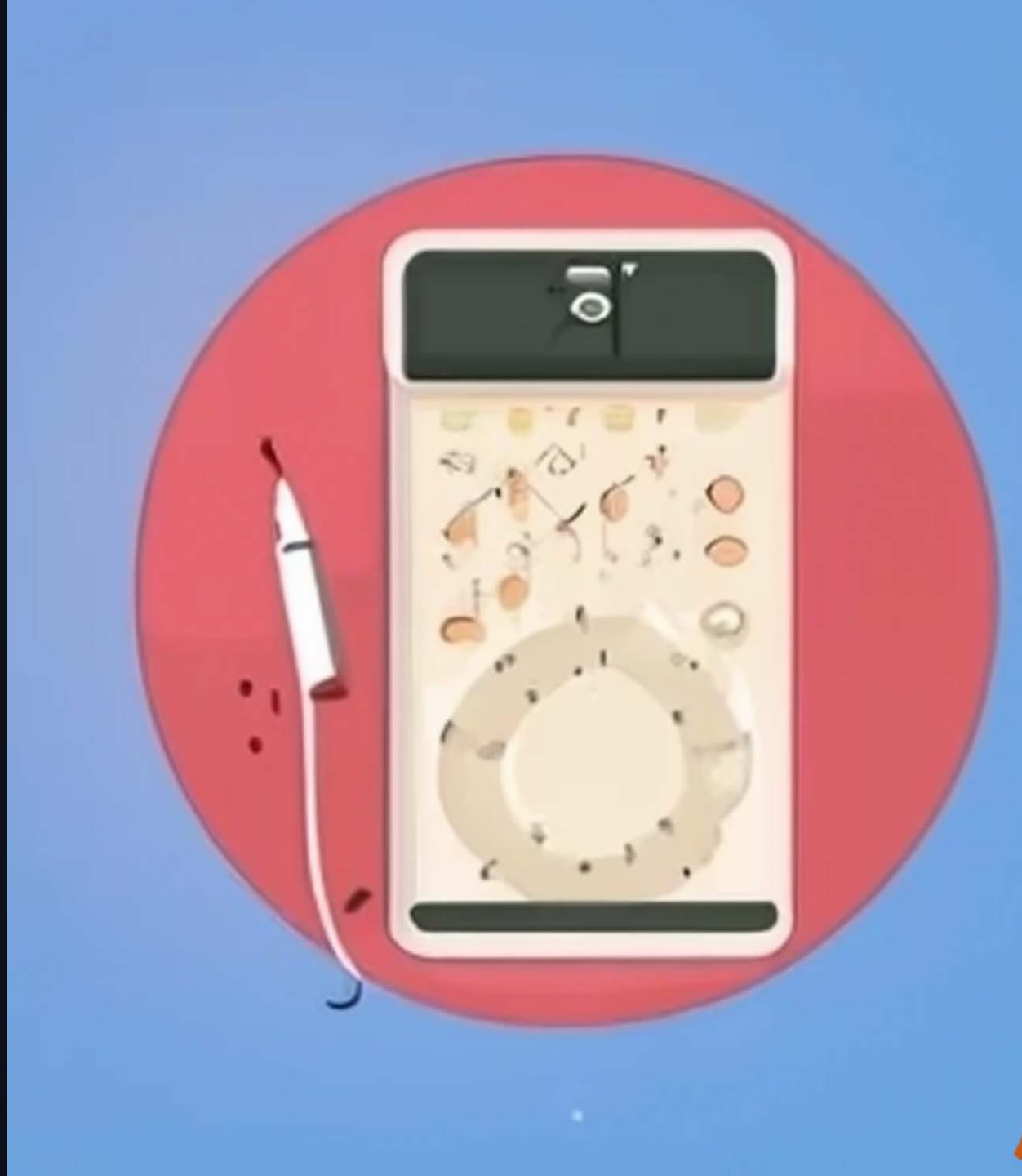


PYOGENIC SALT
MALNOURISHMENT
Ω 3
CONTRACEPTION
NEW INGREDIENT
NEXT UP IN...
LIVE
COOKING
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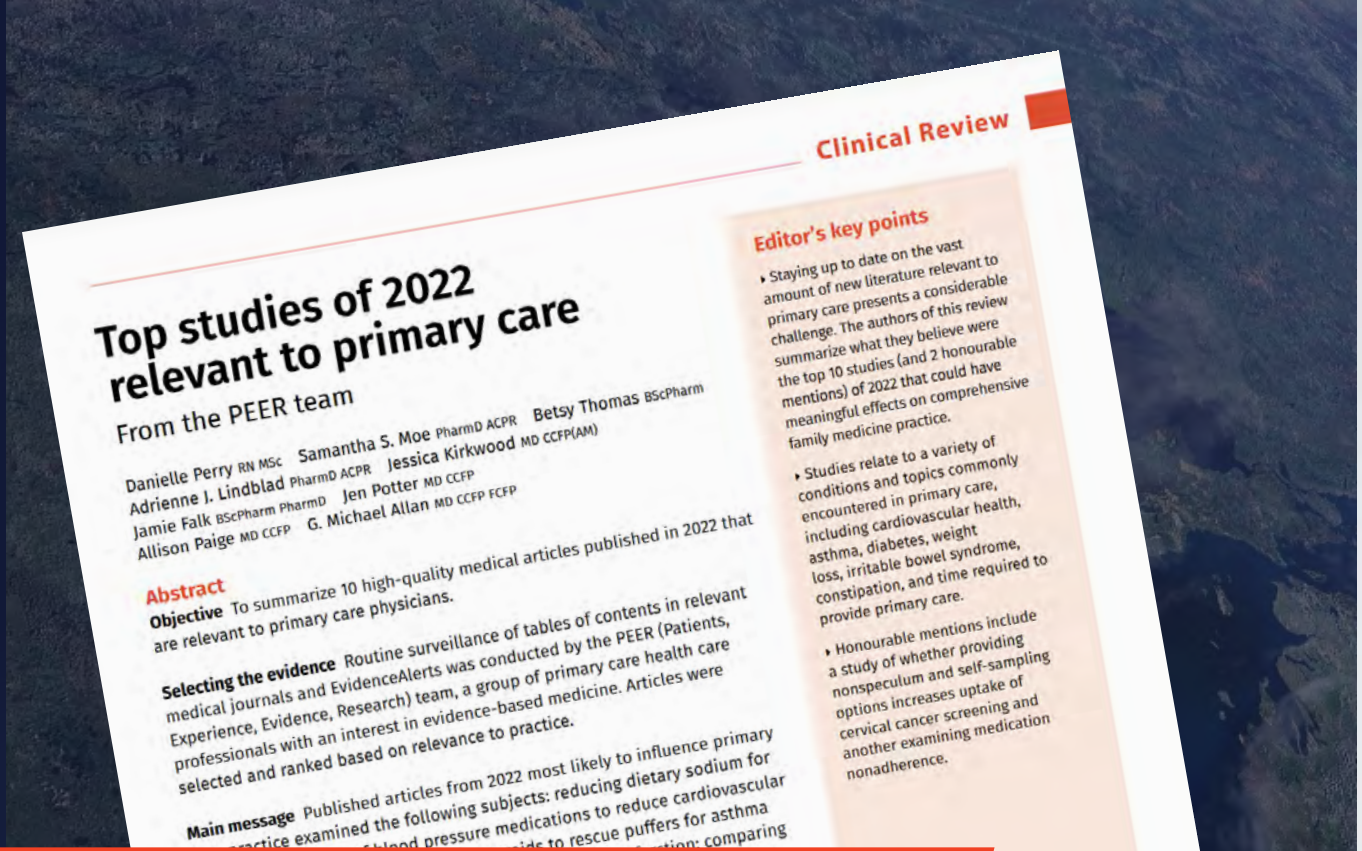
CFP May 2023, 69 (5) 325–329



COOKING

NEW INGREDIENT FOR WEIGHT LOSS

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CFP May 2023, 69 (5) 325–329

- *Previously for Type 2 Diabetes glycemic control*
- *Up to 20% of body weight loss in trial for obesity*

  Semaglutide: ~16%, Liraglutide: ~6%
- *Side effects: nausea*

Double–blind RCT, n=2539

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TIRZEPATIDE: FIRST–IN–CLASS "TWINCRETIN"

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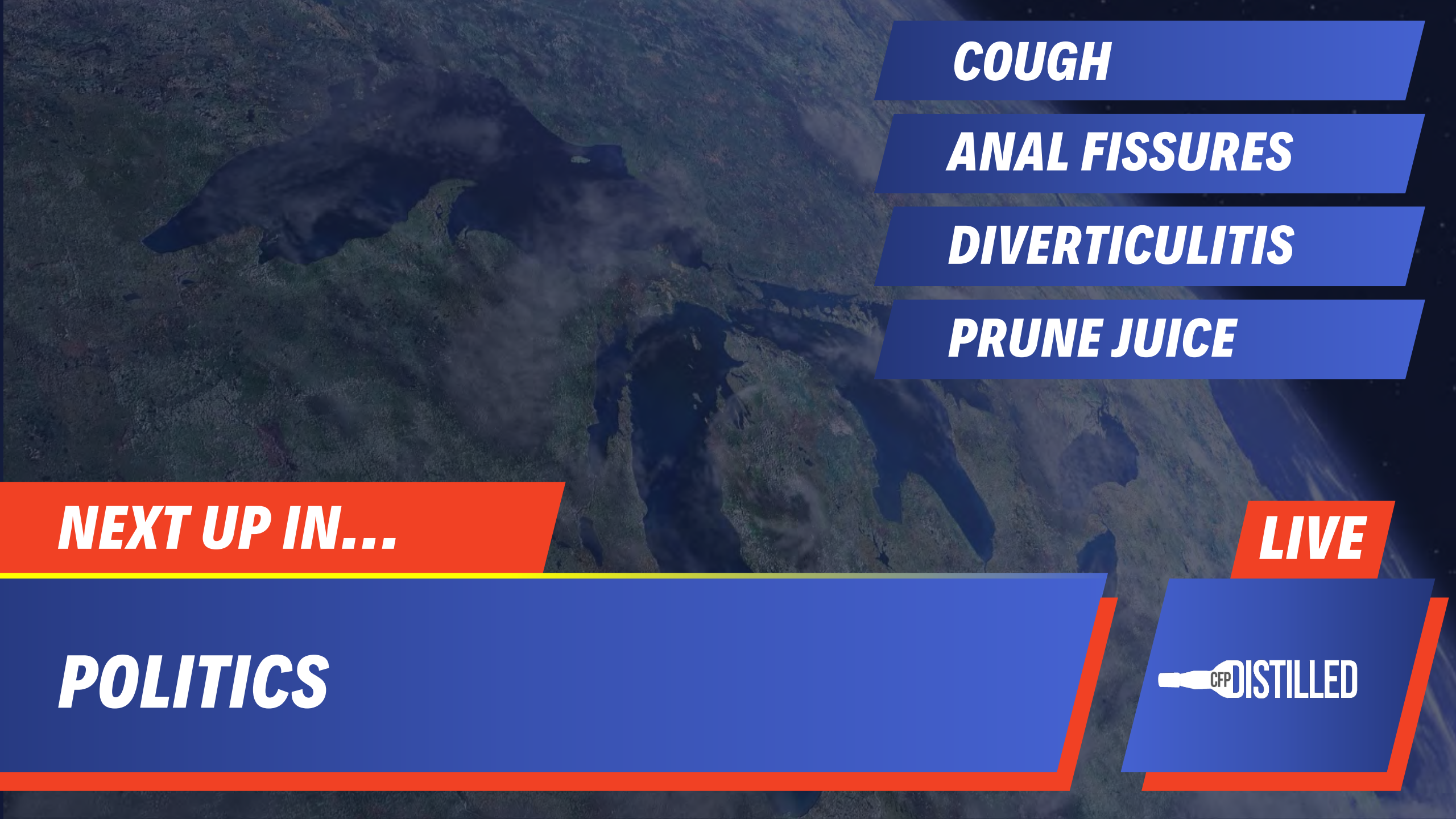
COUGH
ANAL FISSURES
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PRUNE JUICE
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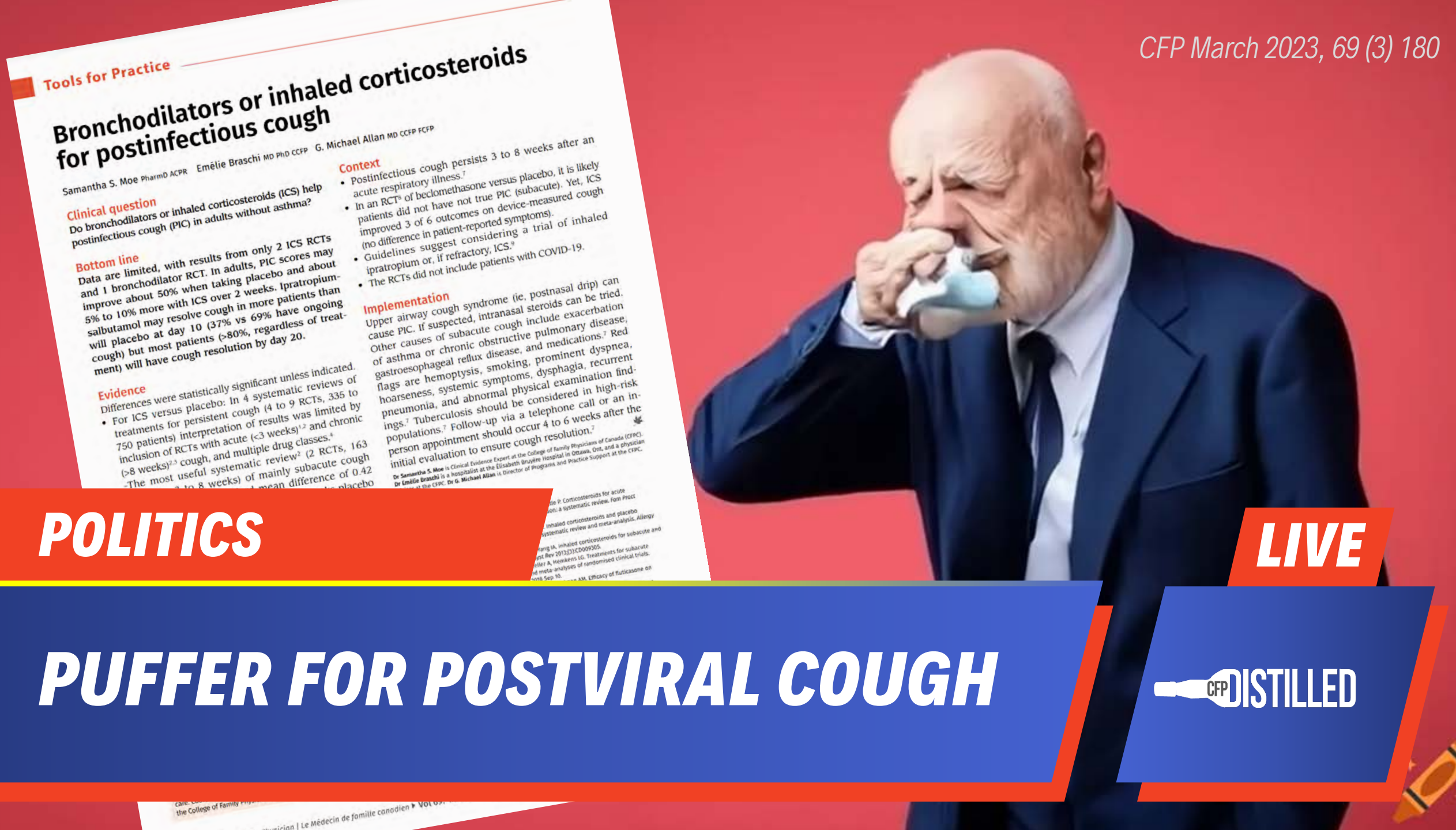
CFP March 2023, 69 (3) 180



POLITICS

PUFFER FOR POSTVIRAL COUGH

LIVE

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CFP March 2023, 69 (3) 180

STEROID OR BRONCHODILATOR?

- *Ipratropium–salbutamol: More cough resolved at day 10 (37% vs. 69% with placebo)*
- *ICS: More cough score improvement at day 14 (40–45% vs. 50% with placebo)*

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POSTVIRAL COUGH

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CFP Jan 2023, 69 (1) 33

Tools for Practice

Topical treatments for anal fissure

Callie Fagan BSP Michael R. Kolber MD CCFP MSc Adrienne J. Lindblad BSP PharmD ACPR

Clinical question

How effective are topical treatments (calcium channel blockers [CCBs], nitrates, and vitamin E) for chronic anal fissures in adults?

Bottom line

Healing rates with topical nitroglycerin are roughly 60% versus 40% with placebo at 8 weeks. Topical CCBs are at least as good as nitroglycerin, with a lower risk of headache (7% versus 56%). Based on 1 RCT, topical vitamin E may be superior to nitroglycerin (86% versus 66% healed at 8 weeks).

Evidence

Five meta-analyses of RCTs from the past 10 years were identified.[1-5] Adjunctive treatments were usually unclear (often fibre therapy or dietary advice). Healing was defined based on examination findings or patient report. Results were statistically significant unless indicated. blockers (eg, 2% diltiazem ointment); 60 to 727 patients),

Context

- Guidelines recommend topical CCBs.[7] Botulinum toxin injections and surgery are options for treatment failure, but fecal incontinence is possible.[7]
- For an 8-week treatment, compounded topical CCBs or nitroglycerin cost roughly $60 per 30 g (personal communication from Stacy Jardine, Clinical Pharmacist, Peace River Value Drug Mart in Peace River, Alberta; 2022). Commercially available vitamin E ointment costs about $10 per 50 g.[8]

Implementation

Anal fissures are commonly found in middle-aged adults and in children.[9] They are primarily diagnosed by clinicians, with symptoms including pain during or after passage of stool, rectal bleeding, and linear tear (with or without a sentinel tag).[10] Most fissures are at the midline. Fissures not in the midline should be investigated for secondary causes (eg, Crohn disease).[11] Differential diagnosis of severe anal pain includes fissure, thrombosed hemorrhoids, or perirectal abscess.[9] Rectal bleeding is not necessarily diagnostic of malignancy but requires assessment and consideration of other risks factors.[12]

Dr Michael R. Kolber is at Calgary Co-op in Alberta. ... Professor in the Department of Family

A, Weston M, Connolly A, et al. A systematic review
cal sphincterotomy treatments for anal fissure.
2021 Oct 4.
Non surgical therapy for anal fissure. Cochrane Database
... 2017 Aug 9.

lations or did ... unblinded, underdosed nitrogly...

POLITICS

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ANAL FISSURE TREATMENTS

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CFP Jan 2023, 69 (1) 33

HEALING RATES

	NNT	
• CCB	3	
• Nitroglycerin	4	18% stop due to headache
• Vitamin E	5	

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ANAL FISSURE TOPICAL TREATMENTS

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CFP Sep 2022, 68 (9) 664–666


Praxis

Rapid recommendations

Updates from 2021 guidelines: part 1

Danielle O'Toole MD MSc CCFP

Before physicians can incorporate evolving guideline evidence into their practices, they must first be able to identify salient key updates, which can be buried in lengthy articles. That barrier can delay the integration of novel approaches into clinical care. This article is the first in a 2-part series focusing on key guideline recommendations that were updated or introduced in 2021. Family physicians are always encouraged to appraise each recommendation prior to considering its implementation, as some recommendations are based on low-quality evidence or expert opinion.

Guideline updates

For secondary prevention, the Canadian Cardiovascular Society (CCS) recommends additional non-statin therapy for patients taking maximally tolerated statin therapy and with low-density lipoprotein cholesterol levels of 1.8 mmol/L or greater (or non–high-

acid with 1 additional risk factor, as well as for patients with stable cardiovascular disease or peripheral arterial disease prescribed combination therapy.

The CCS and the CHRS suggest a blood pressure target of 130/80 mm Hg or less for patients with atrial fibrillation (strength of recommendation and quality of evidence not provided).[4] Hypertension Canada guidelines do not list patients with atrial fibrillation as a specific population.[5] However, the authors of the 2020 CCS and CHRS guidelines on atrial fibrillation recommend a target blood pressure of 130/80 mm Hg or less at rest and 200/100 mm Hg or less at peak exercise, with angiotensin-converting enzyme inhibitors (ACEIs) being the preferred treatment option.[4] This recommendation is consistent with multiple guidelines from other countries.[6-9]

The CCS and the Canadian Heart Failure Society recommend that patients with heart failure with reduced ejection fraction (HFrEF) be treated with 1 evidence-based medication from each of the following categories: angiotensin receptor–neprilysin inhibitor (ARNI) (or receptor blocker [ARB]); β-blocker; antagonist; and sodium-bitor (strong recommendation, ence).[10] The previous guideline ACEI as the first-line therapy if the patient remained symptomatic dose of the ACEI. Although the is still an indication to start an superiority of ARNIs in

effects for pa... combination anticoagulant... (weak recommendation, moderate-q... RCTs investigating the use of oral anticoagulants for

not provided). described good asthma control as... daytime symptoms or the need for fewer

POLITICS

LIVE

UNCOMPLICATED DIVERTICULITIS = NO ANTIBIOTICS

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CFP Sep 2022, 68 (9) 664–666

ANTIBIOTICS = NO DIFFERENCE IN:

- *Time to resolution*
- *Readmission or surgery*
- *Complications*

Only if uncomplicated (i.e. no comorbidities, no frailty, no vomiting, normal CRB / WBC)

LIVE

UNCOMPLICATED DIVERTICULITIS = NO ANTIBIOTICS

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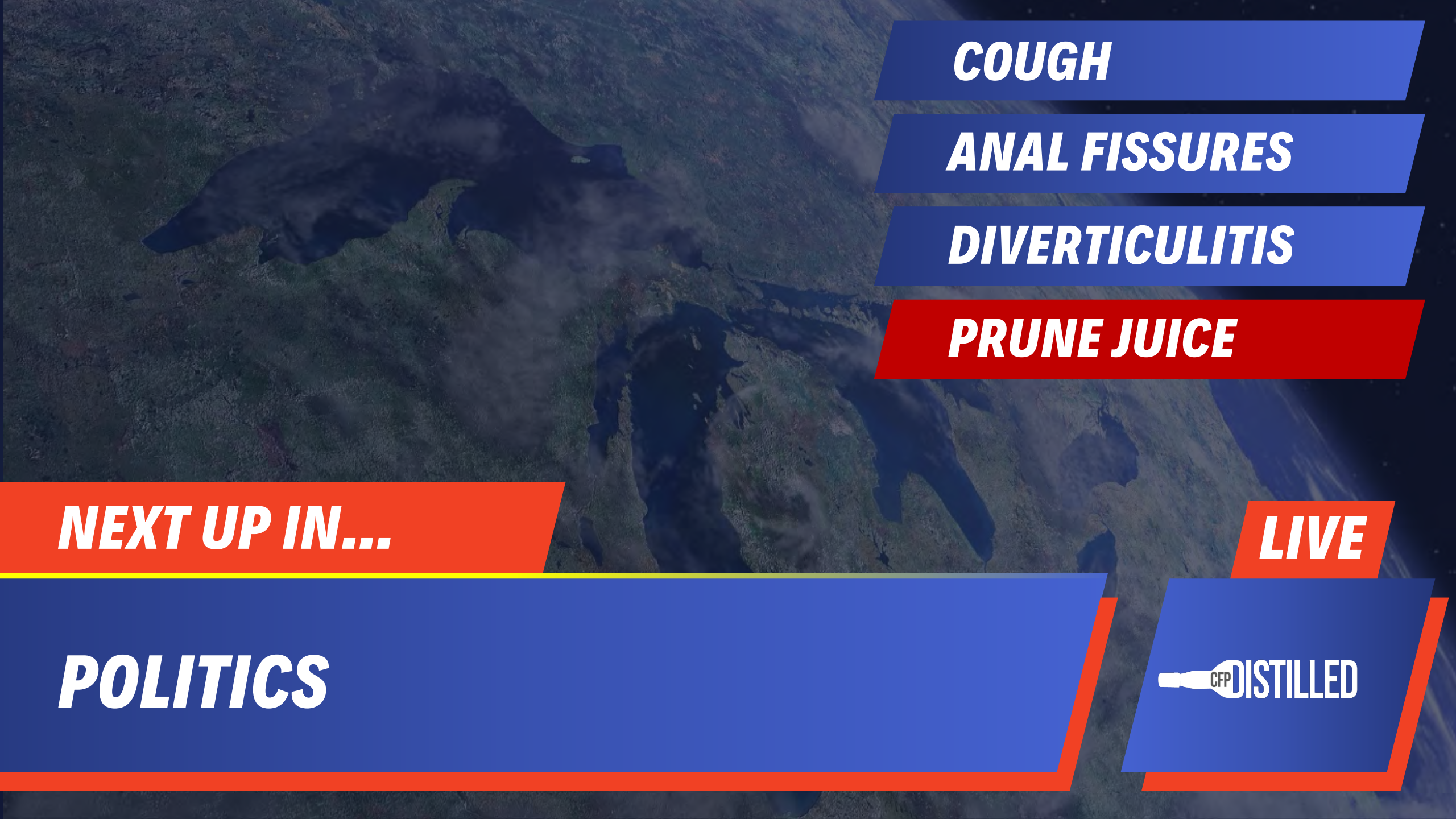
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CFP May 2023, 69 (5) 325–329

Clinical Review

Top studies of 2022 relevant to primary care

From the PEER team

Danielle Perry RN MSc Samantha S. Moe PharmD ACPR Betsy Thomas BScPharm
Adrienne J. Lindblad PharmD ACPR Jessica Kirkwood MD CCFP(AM)
Jamie Falk BScPharm PharmD Jen Potter MD CCFP
Allison Paige MD CCFP G. Michael Allan MD CCFP FCFP

Abstract

Objective To summarize 10 high-quality medical articles published in 2022 that are relevant to primary care physicians.

Selecting the evidence Routine surveillance of tables of contents in relevant medical journals and EvidenceAlerts was conducted by the PEER (Patients, Experience, Evidence, Research) team, a group of primary care health care professionals with an interest in evidence-based medicine. Articles were selected and ranked based on relevance to practice.

Main message Published articles from 2022 most likely to influence primary practice examined the following subjects: reducing dietary sodium for blood pressure medications to reduce cardiovascular ids to rescue puffers for asthma tion; comparing

Editor's key points

- Staying up to date on the vast amount of new literature relevant to primary care presents a considerable challenge. The authors of this review summarize what they believe were the top 10 studies (and 2 honourable mentions) of 2022 that could have meaningful effects on comprehensive family medicine practice.
- Studies relate to a variety of conditions and topics commonly encountered in primary care, including cardiovascular health, asthma, diabetes, weight loss, irritable bowel syndrome, constipation, and time required to provide primary care.
- Honourable mentions include a study of whether providing nonspeculum and self-sampling options increases uptake of cervical cancer screening and another examining medication nonadherence.

Journal of Medicine, the ... and the American College of ... relevant to primary care practice. Identi... primary care professionals. Owing to ... we searched publica... time

POLITICS

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PRUNE JUICE MAY BE EFFECTIVE FOR CONSTIPATION

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CFP May 2023, 69 (5) 325–329

PRUNE PRESCRIPTION

- 54g / day = 50% had normal BMs vs. placebo (25%)
- Single industry–sponsored trial, NNT = 4, n=84

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PRUNE JUICE FOR CONSTIPATION

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STEROIDS & MONO
STATINS & MUSCLE
HEART FITNESS
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SPORTS UPDATE
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CFP Feb 2023, 69 (2) 101–102

Corticosteroids for infectious mononucleosis

Kyle Gomes Ran D. Goldman MD FRCPC

Abstract

Question Infectious mononucleosis (IM) is a common viral infection year round, and we see patients with it in our family medicine clinic frequently. With fatigue, fever, pharyngitis, and cervical or generalized lymphadenopathy causing prolonged illness and school absences, we always look for treatments that will shorten the duration of symptoms. Does treatment with corticosteroids benefit these children?

Answer Current evidence points to small and inconsistent benefits when using corticosteroids for symptom relief in children with IM. Corticosteroids alone or in combination with antiviral medications should not be given to children for common symptoms of IM. Corticosteroids should be reserved for those with impending airway obstruction, autoimmune complications, or other severe circumstances.

Corticostéroïdes pour le traitement de la mononucléose infectieuse

Résumé

Question La mononucléose infectieuse (MI) est une infection virale courante tout au long de l'année. Nous voyons souvent des patients qui en sont atteints à notre clinique de médecine familiale. Étant donné que la MI se manifeste par de la fatigue, de la fièvre, une pharyngite et une adénopathie cervicale ou généralisée causant une maladie et des absences de l'école prolongées, nous sommes toujours à l'affût de traitements qui réduiront la durée des symptômes. Le traitement par corticostéroïdes est-il bénéfique pour ces enfants?

Réponse Selon les données actuelles, le recours à des corticostéroïdes pour le soulagement des symptômes des enfants atteints de MI procurerait des bienfaits faibles et inégaux. On ne doit pas administrer des corticostéroïdes seuls ou en association avec des antiviraux aux enfants qui présentent des symptômes courants de MI. Il faut réserver les corticostéroïdes aux enfants chez qui l'obstruction des voies aériennes est imminente, ou à ceux qui présentent des complications auto-immunes ou qui sont confrontés à d'autres circonstances graves.

Corticosteroid use in IM

Corticosteroids exert anti-inflammatory properties through ...actions with inflammatory genes. Specifically, after bind... ...responsive elements alter inflammatory ...s cytokines, chemokines, adhe... ...atory enzymes.[12] Corticosteroids ...s are recommended for patients ...s of IM such as airway obstruction, ...anemia, and thrombocytopenia.[13] ...relief is not considered standard and ...ve varying degrees of efficacy.[7,8] ...7 randomized controlled ...tween 14

have similarly shown ove...

SPORTS

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STEROID USE IN MONO

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CFP Feb 2023, 69 (2) 101–102

IN CHILDREN:

- Cochrane review:
  Small, inconsistent benefit for pain only
- Less pain at 12 hours (but not at 24–36 h)
- Risk of adverse events

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STEROIDS IN MONO

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CFP May 2023, 69 (5) 337

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STATIN MUSCLE MYTHS

CFP May 2023, 69 (5) 337

RATE OF MUSCLE SYMPTOMS

Year 1:

- *Year 1: Placebo: 14%*
- *Statins: 14.8%*

After year 1: Similar

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STATIN MYTHS

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Rapid recommendations

Updates from 2022 guidelines: part 1

Danielle O'Toole MD MSc CCFP

Staying current with evolving guideline evidence is crucial in medicine, yet the sheer volume of lengthy articles being published can make this challenging. This article is the first in a 3-part series summarizing clinical guideline recommendations updated in 2022 that are relevant to primary care in Canada. As always, family physicians are advised to appraise the recommendations before considering implementation, as some may be based on low-quality evidence or expert opinion.

Guideline updates

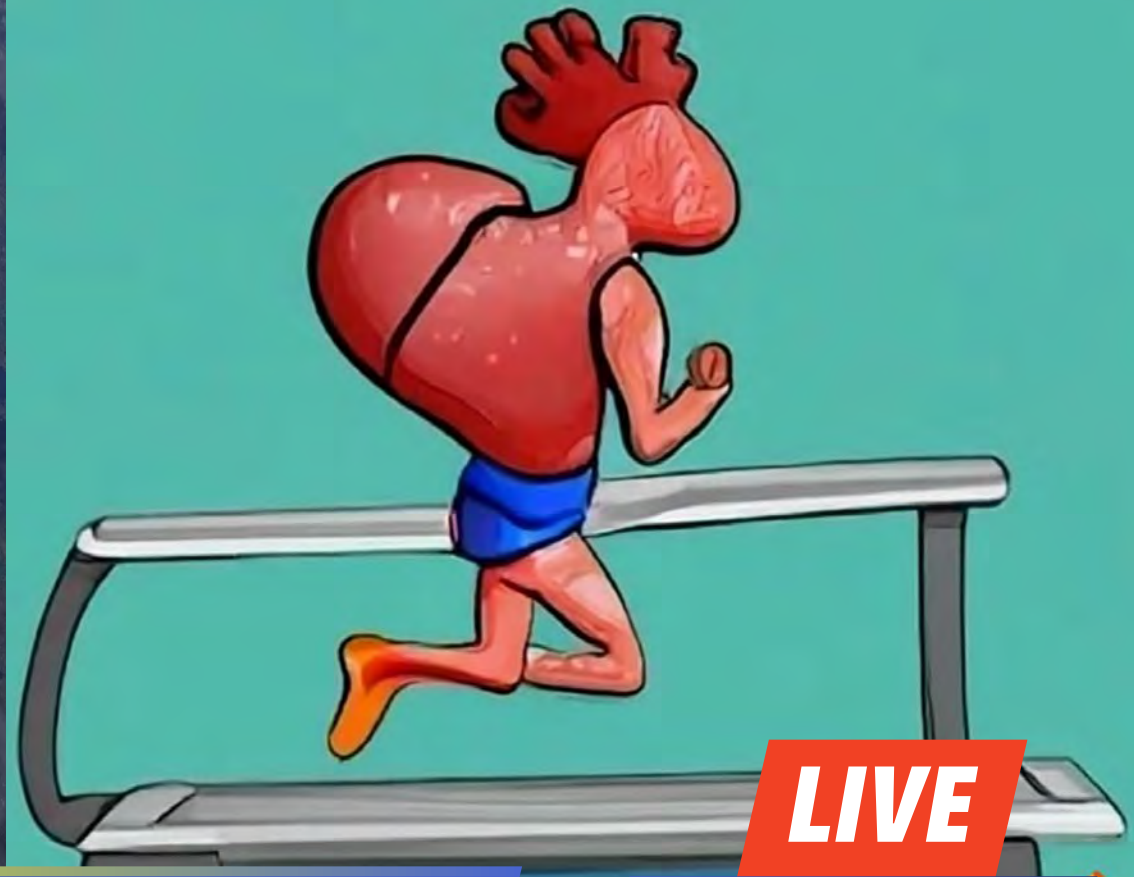
The Canadian Cardiovascular Society (CCS) and Canadian Pediatric Cardiology Association issued new guidelines recommending universal screening for dyslipidemia in children aged 2 to 10 (expert opinion).[1] This guideline was developed based on the prevalence of familial hyperlipidemia (approximately 1 in 300 Canadians), ease of detection, and availability of effective management options. Furthermore, the American College of Cardiology (ACC) and American Heart Association (AHA) 2018 guideline also recognizes the importance of pediatric lipid screening; according to children with a family history of early car- hypercholesterolemia should

of B-type natriuretic peptides.[3] This 2022 guideline recommends the use of angiotensin-converting enzyme inhibitors (ACEIs) (class 1 recommendation, level A evidence) and β-blockers (class 1 recommendation, level C evidence) for patients with left ventricular ejection fraction (LVEF) less than or equal to 40% to prevent symptomatic HF and reduce mortality.

The ACC and AHA and the CCS recommend consideration of sodium-glucose cotransporter-2 inhibitors (SGLT2Is) to reduce risks of hospitalization and cardiac death in patients with HF, including those with HF with mildly reduced ejection fraction (LVEF 41% to 49%), HF with improved ejection fraction (LVEF previously ≤40% but now >40%), or HF with preserved ejection fraction (HFpEF; LVEF >50%) (class 2a recommendation).[3,4] The EMPEROR-Preserved (Empagliflozin Outcome Trial in Patients with Chronic Heart Failure with Preserved Ejection Fraction) study demonstrated a reduction in rates of hospitalization and CV death but not in all-cause mortality in patients taking empagliflozin with symptomatic HF and LVEF greater than 40%.[3] The ACC and AHA continue to recommend guideline-directed medical therapy, including the use of ACEIs, β-blockers, and mineralocorticoid receptor antagonists (MRAs) for patients with HF with improved ejection fraction and consideration of the same for patients with HF with mildly reduced ejection fraction. For patients with HFpEF, consider an MRA

evel is less than 5.0 mmol/L
filtration rate (eGFR) is greater
m² to improve diastolic func-
and decrease the risk of hospi-
lly, in a post hoc group analysis,
e a possible benefit of angiotensin
inhibitor in women with HFpEF with

changes or have risk fac



SPORTS UPDATE

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CARDIAC FITNESS

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CFP May 2023, 69 (5) 338–339

TREAT* PRE-HEART FAILURE IF

No symptoms and:

- *Structural changes, or*
- *Risk factors, or*
- *Elevated BNP*

*ß blocker & ACE inhibitor & ACC, AHA, HFSA 2022 Guideline

SPORTS UPDATE

LIVE

PRE-HEART FAILURE

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CFP March 2023, 69 (3) 181
CFP May 2023, 69 (5) 338–339

NEW TERMS

HFpEF

- *No medications reduce all–cause mortality*
- *SGLT–2 inhibitors ↓ CV death, ↓ admissions, ↑ QOL*

HFrEF:

- *ACEi, ß blocker, MRA, SGLT–2i*

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HEART FAILURE

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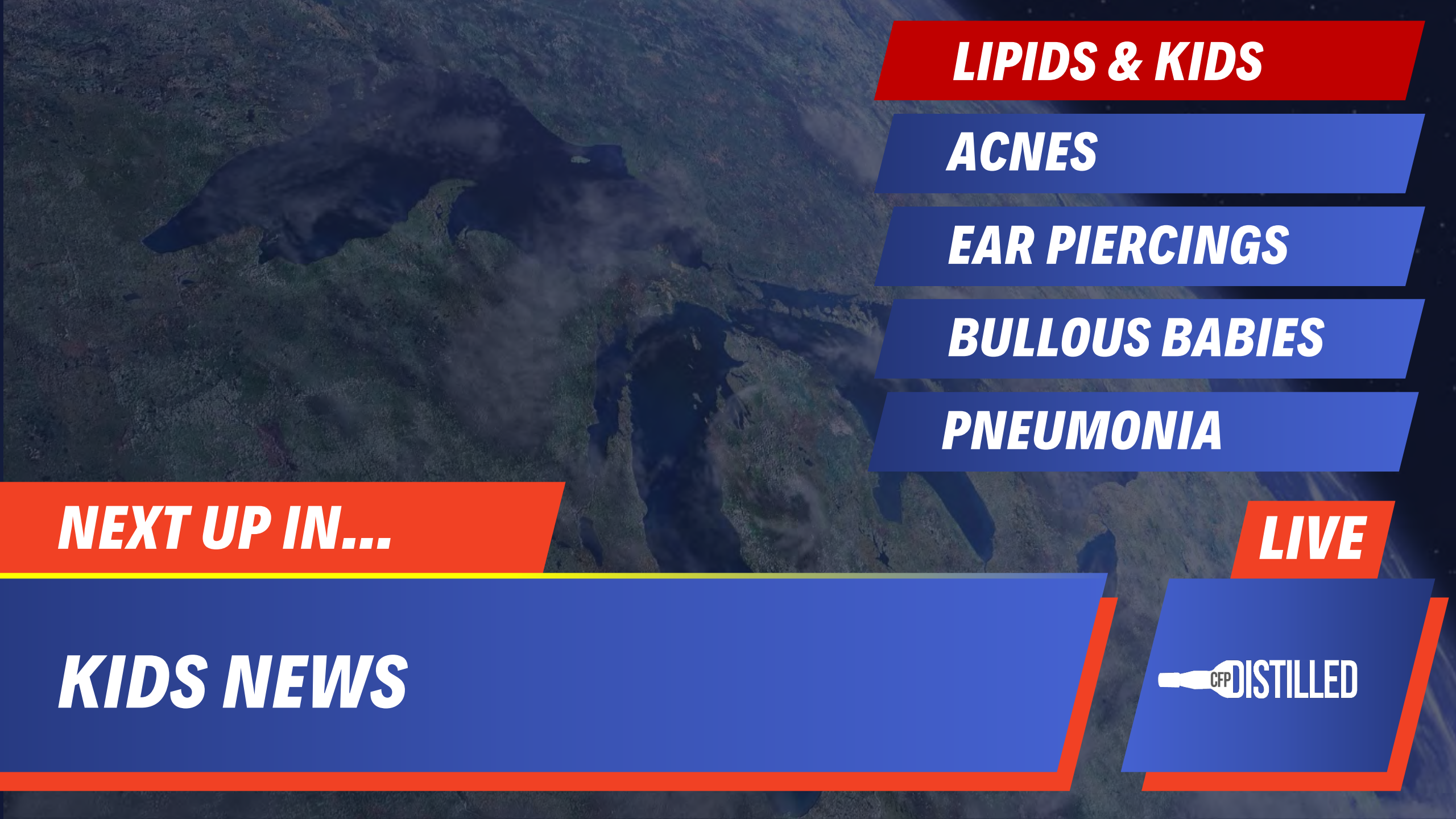
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Rapid recommendations

Updates from 2022 guidelines: part 1

Danielle O'Toole MD MSc CCFP

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of B-type natriuretic peptides.[3] This 2022 guideline recommends the use of angiotensin-converting enzyme inhibitors (ACEIs) (class 1 recommendation, level A evidence) and β-blockers (class 1 recommendation, level C evidence) for patients with left ventricular ejection fraction (LVEF) less than or equal to 40% to prevent symptomatic HF and reduce mortality.

The ACC and AHA and the CCS recommend consideration of sodium-glucose cotransporter-2 inhibitors (SGLT2Is) to reduce risks of hospitalization and cardiac death in patients with HF, including those with HF with mildly reduced ejection fraction (LVEF 41% to 49%), HF with improved ejection fraction (LVEF previously ≤40% but now >40%), or HF with preserved ejection fraction (HFpEF; LVEF >50%) (class 2a recommendation).[3,4] The EMPEROR-Preserved (Empagliflozin Outcome Trial in Patients with Chronic Heart Failure with Preserved Ejection Fraction) study demonstrated a reduction in rates of hospitalization and CV death but not in all-cause mortality in patients taking empagliflozin with symptomatic HF and LVEF greater than 40%.[3] The ACC and AHA continue to recommend guideline-directed medical therapy, including the use of ACEIs, β-blockers, and mineralocorticoid receptor antagonists (MRAs) for patients with HF with improved ejection fraction and consideration of the same for patients with HF with mildly reduced ejection fraction.[3] In patients with HFpEF, consider an MRA if the serum potassium level is less than 5.0 mmol/L and estimated glomerular filtration rate (eGFR) is greater than 30 mL/min/1.73 m² to improve diastolic function and quality of life and decrease the risk of hospitalization. Additionally, in a post hoc group analysis, there appeared to be a possible benefit of angiotensin [illegible] inhibitor in women with HFpEF with

in patients [illegible] changes or have risk factors [illegible]

LIVE

SCREEN LIPIDS IN ALL KIDS

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CFP May 2023, 69 (5) 338–339
JAMA 2023;330(3):253–260.

UNIVERSAL LIPID SCREENING

- Check all kids age 2–10
- 1 in 300 Canadians have familial hyperlipidemia
- CCS & CPCA, expert opinion

USPSTF:

- Don't
- Unnecessary, maybe harmful

LIVE

SCREEN LIPIDS IN ALL KIDS

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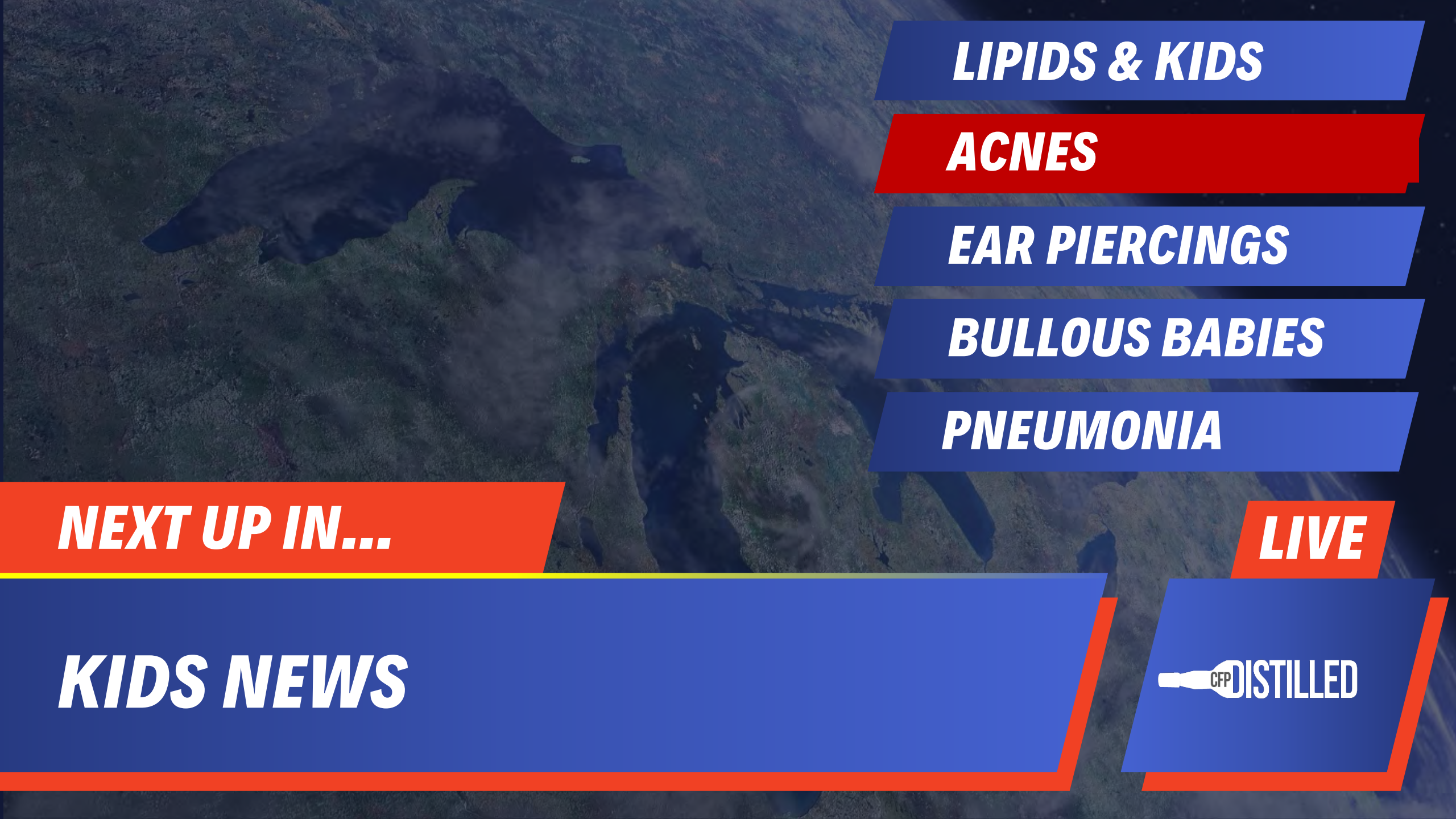
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CFP April 2023, 69 (4) 257–258;

Child Health Update

Anterior cutaneous nerve entrapment syndrome in children

Hiroyuki Hayashi MD Ryutaro Tanizaki MD PhD Yousuke C. Takemura MD PhD Ran D. Goldman MD FRCPC

Abstract

Question I frequently see adolescents with recurrent abdominal pain in my family medicine clinic. While the diagnosis frequently is a benign condition such as constipation, I recently heard that after 2 years of recurrent pain, an adolescent was diagnosed with anterior cutaneous nerve entrapment syndrome (ACNES). How is this condition diagnosed? What is the recommended treatment?

Answer Anterior cutaneous nerve entrapment syndrome, first described almost 100 years ago, is caused by entrapment of the anterior branch of the abdominal cutaneous nerve as it pierces the anterior rectus abdominis muscle fascia. The limited awareness of the condition in North America results in misdiagnosis and delayed diagnosis. Carnett sign—in which pain worsens when using a "hook-shaped" finger to palpate a purposefully tense abdominal wall—helps to confirm if pain originates from the abdominal viscera or from the abdominal wall. Acetaminophen and nonsteroidal anti-inflammatory drugs were not found to be effective, but ultrasound-guided local anesthetic injections seem to be an effective and safe treatment for ACNES, resulting in relief of pain in most adolescents. For those with ACNES and ongoing pain, surgical cutaneous neurectomy by a pediatric surgeon should be considered.

Recurrent chronic abdominal pain is common among children and adolescents, and diagnosis may be challenging.[1] Abdominal pain may disrupt daily routines for patients and their families[2] and impact their quality of life.[1] The pathology leading to acute and chronic abdominal pain in children, especially pain in the abdominal wall, may be difficult to classify.[3] Common reasons for severe pain include gastroenteritis, constipation, and systemic viral illness. More severe illnesses needing immediate attention are appendicitis, intussusception, cholecystitis, pancreatitis, testicular or ovarian pain (torsion), entrapped (incarcerated) hernias, and chronic appendicitis.[4,5]

Forgotten diagnosis

One diagnosis frequently overlooked in both adults and [illegible] anterior cutaneous nerve entrapment syndrome, first described almost 100 years ago.[6] In [illegible] forgotten

up to 10% to 30% of patients with chronic abdominal wall pain.[12] Some case reports of children 9 to 16 years of age have documented the condition in several countries,[13,14] and among 48 adolescents with ACNES at Boston Children's Hospital in Massachusetts, 9 required surgery.[15]

The limited awareness of the condition results in misdiagnosis of conditions in which pain arises from a visceral source, often resulting in unnecessary diagnostic testing, ongoing pain, and considerable cost.[11] Some children were considered to have functional abdominal pain[16] or mental health–related conditions that resulted in delays in definitive diagnosis.[9]

While reported to be associated with previous surgeries and adhesions, most pediatric patients with the condition do not have a history of surgery. In some, ACNES seems to be associated with sporting events antecedent to onset of pain,[15] but by far most patients do not report any trauma to the abdominal wall.

Characterization of the pain in children may vary, but [illegible] will report sharp stabbing pain that [illegible] minal muscles, as well [illegible] pain

Netherlands, [illegible] abdominal pain seen in gastr[illegible]

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"THE FORGOTTEN DIAGNOSIS"

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COMMONLY MISSED

- Anterior Cutaneous Nerve Entrapment Syndrome (ACNES)
- Diagnose with Carnett's sign
- Treat with US–guided local anesthetic injection

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"THE FORGOTTEN DIAGNOSIS"

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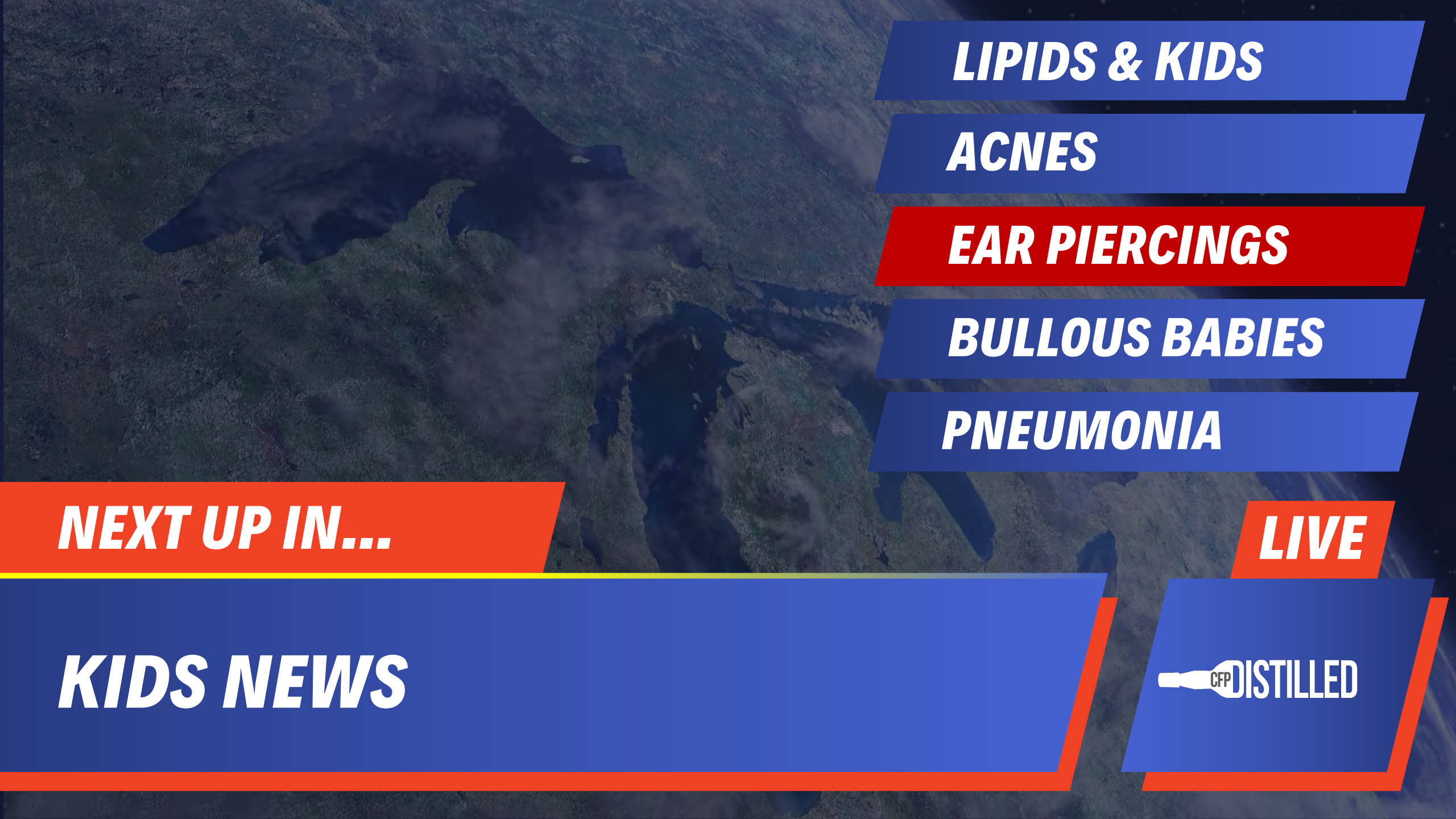
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CFP Sep 2022, 68 (9) 661–663

Ear-piercing complications in children and adolescents

Michelle M. Kim Ran D. Goldman MD FRCPC

Abstract

Question Ear piercing is one of the most common forms of body modification seen in children and adolescents presenting to my office. Parents of my younger pediatric patients inquire about potential post-piercing complications and risk factors associated with earlobe infections. What guidance should I give them? Also, are there any specific post-piercing complications to consider for older pediatric patients seeking second piercings in the upper cartilage area?

Answer Piercing the earlobe or auricular cartilage continues to be a popular procedure among children and adolescents. Despite its widespread practice, improper aseptic piercing technique, insufficient training, and trauma to the soft tissue during high-pressure piercing (eg, use of spring-loaded ear-piercing instruments) can increase one's susceptibility to infections, bleeding, and microfractures. Other post-piercing complications include embedded earrings, keloids, hypertrophic scarring, and cutaneous hypersensitivity. Early recognition and treatment of infections and perichondritis secondary to transcartilaginous piercings can prevent the progression of severe ear deformities requiring reconstructive surgical interventions.

Complications du perçage des oreilles chez les enfants et les adolescents

Résumé

Question Le perçage des oreilles est l'une de formes de modifications corporelles que je vois communément chez les enfants et les adolescents qui viennent à ma clinique. Les parents de mes plus jeunes patients pédiatriques s'informent des complications potentielles à la suite du perçage des oreilles et des facteurs de risque associés aux infections des lobes d'oreille. Quels conseils devrais-je leur donner? De plus, y a-t-il des complications particulières dont il faut tenir compte à la suite des perçages chez les patients pédiatriques plus âgés qui en veulent d'autres, dans la région du cartilage supérieur?

Réponse Le perçage des lobes d'oreilles ou du cartilage auriculaire continue d'être une procédure populaire chez les enfants et les adolescents. Malgré la généralisation de cette pratique, une technique de perçage mal aseptisée, une formation insuffisante et un traumatisme aux tissus mous durant un perçage à haute pression (p. ex. le recours à des instruments de perçage d'oreilles à ressort) peuvent accroître la susceptibilité d'une personne à des infections, des saignements et des microfractures. Parmi d'autres complications ultérieures à un perçage figurent l'incrustation des cicatrices chéloïdes ou hypertrophiques et une hypersensibilité cutanée. La détection et le des périchondrites secondaires à des perçages à travers le cartilage peuvent prévenir qui exigeraient des interventions chirurgicales de reconstruction.

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EAR–PIERCING COMPLICATIONS

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COMPLICATIONS:

- Embedded
- Keloids / hypertrophic scarring
- Nickel–allergic contact dermatitis
- Auricular perichondritis

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EAR–PIERCING

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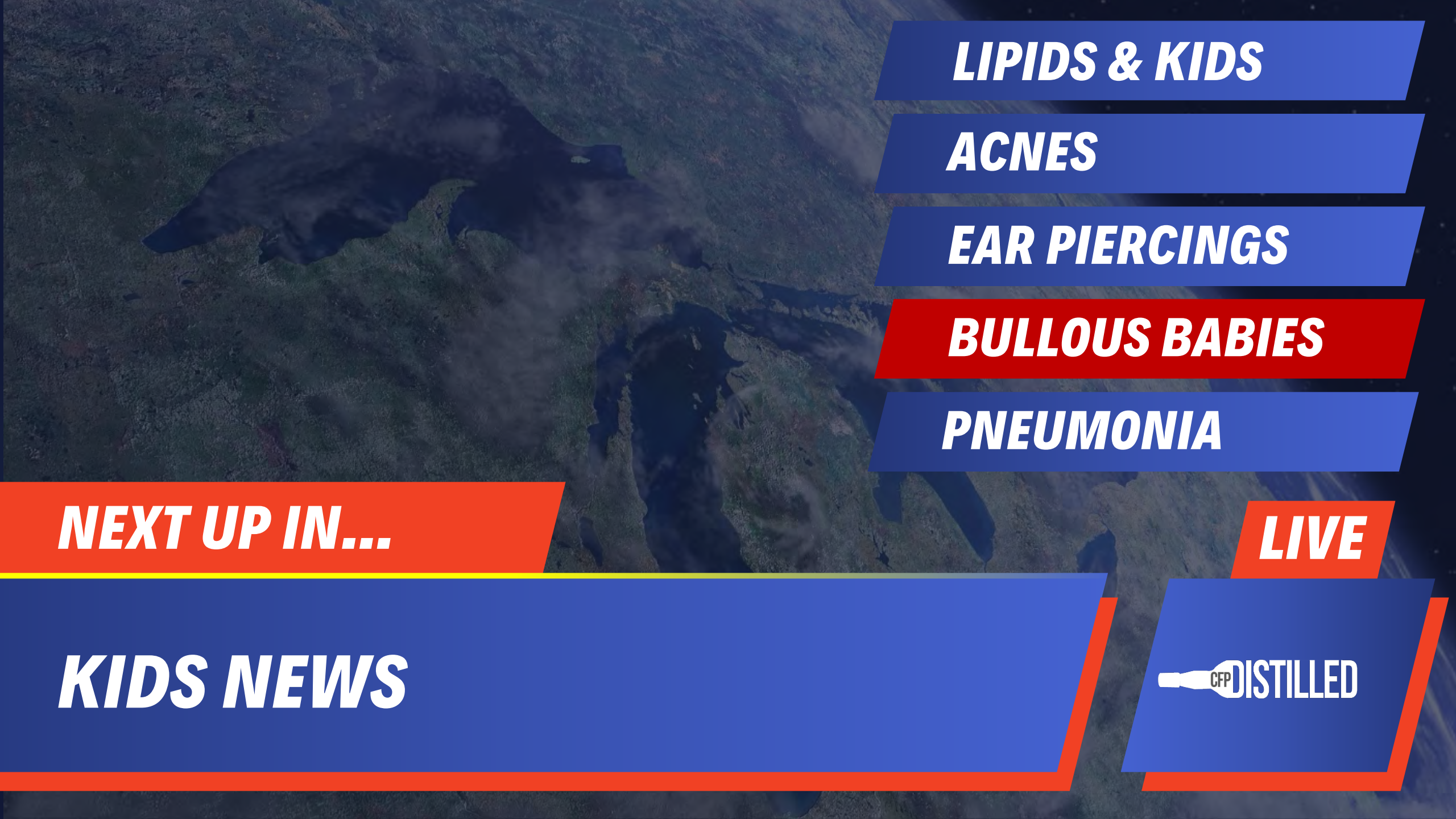
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Case Report

Not all that blisters is infectious

Rosalind Ashton MD CCFP Caroline Mahon MD FRACP

Editor's key points

- Chronic bullous disease of childhood is the most common pediatric autoimmune bullous disease. It presents with tense blisters, often in the classic string-of-pearls or crown-of-jewels pattern.
- The condition is often self-limiting and can resolve spontaneously without treatment. Mild cases can be treated with topical corticosteroids.
- Dapsone or sulfapyridine are the first-line systemic treatments, and the patient's glucose-6-phosphate dehydrogenase level must be measured before starting these medications. Other treatments include colchicine and penicillin or macrolide antibiotics.
- The differential diagnoses for skin blistering in infants and children are extensive and include both common and very rare disorders. If infectious causes have been excluded and autoimmune blistering is suspected, referral to a pediatric dermatologist is recommended.

Points de repère du rédacteur

- La maladie chronique bulleuse de l'enfance est la plus commune des affections bulleuses auto-immunes pédiatriques. Elle se présente sous la forme de cloques tendues, souvent semblable à un collier de perles ou à des joyaux sur une couronne.
- L'affection se résorbe souvent d'elle-même et peut disparaître [illegible] traitement. Les

A child who presents with blistering that is not due to an infectious cause can represent a diagnostic challenge for primary care physicians. Pediatric autoimmune bullous diseases encompass several very uncommon blistering skin conditions, including chronic bullous disease of childhood (CBDC), pemphigus vulgaris and pemphigus foliaceus, bullous pemphigoid, dermatitis herpetiformis, and epidermolysis bullosa acquisita. The hallmark of these diseases is bullae or blistering caused by autoantibody-mediated disruption of the structural anchoring components of the epidermis that results in microscopic and macroscopic cleavage, either intraepidermal or subepidermal.

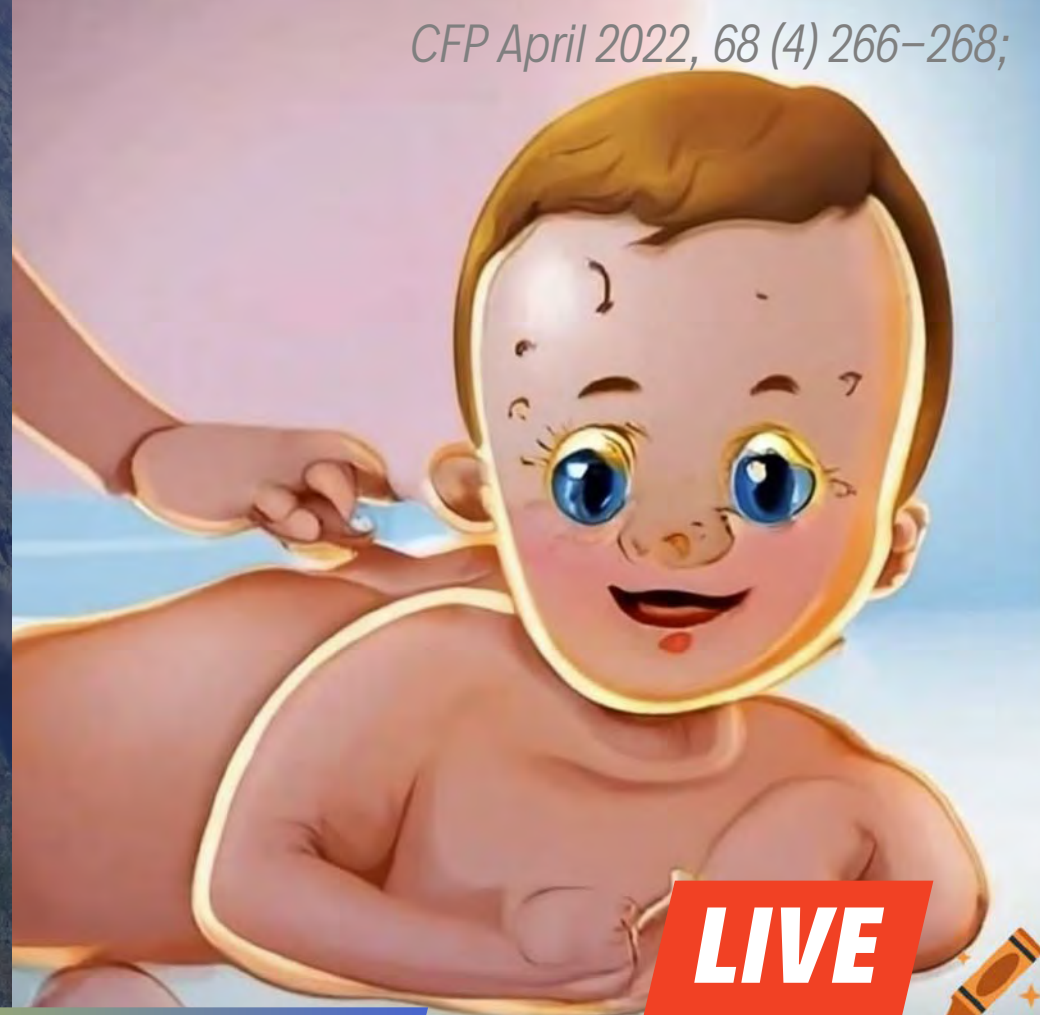
We report a case of a child with a classic clinical presentation of CBDC, characterized by the crown-of-jewels or string-of-pearls sign, in which vesicles and bullae form in close proximity with an annular morphology. The presentation may mimic herpes simplex and varicella zoster virus infection. A comprehensive search of MEDLINE, EMBASE, and Scopus databases using the key words *CBDC, linear IgA disease,* and *pediatric autoimmune bullous disease* allowed for the collection of English-language articles.

Case

An 11-year-old girl with an unremarkable medical and family history presented to the emergency department with multiple annular blistering plaques on her upper back. There was no mucosal or scalp involvement. She was diligently applying medium-potency topical corticosteroid and 1% mupirocin ointments to the lesions, without benefit. Findings of a systems inquiry were negative. On examination, we observed a polycyclic eruption of annularly arranged vesicles—the classical string-of-pearls pattern—extending across the patient's upper back (**Figure 1**). Findings on examination of the rest of her skin, mucous membranes, nails, and hair, as well as her lymph nodes, abdominal viscera, and chest, were unremarkable.

Discussion

The approach to differential diagnosis of skin blistering in children varies with the age at presentation. In infancy and in school-aged children, infectious [illegible] are most common; therefore, excluding infections such as herpes simplex virus, bullous impetigo, and staphylococcal scalded [illegible] and viral swabs are essential for micros- [illegible] children, blistering due to



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BLISTERING DISEASE

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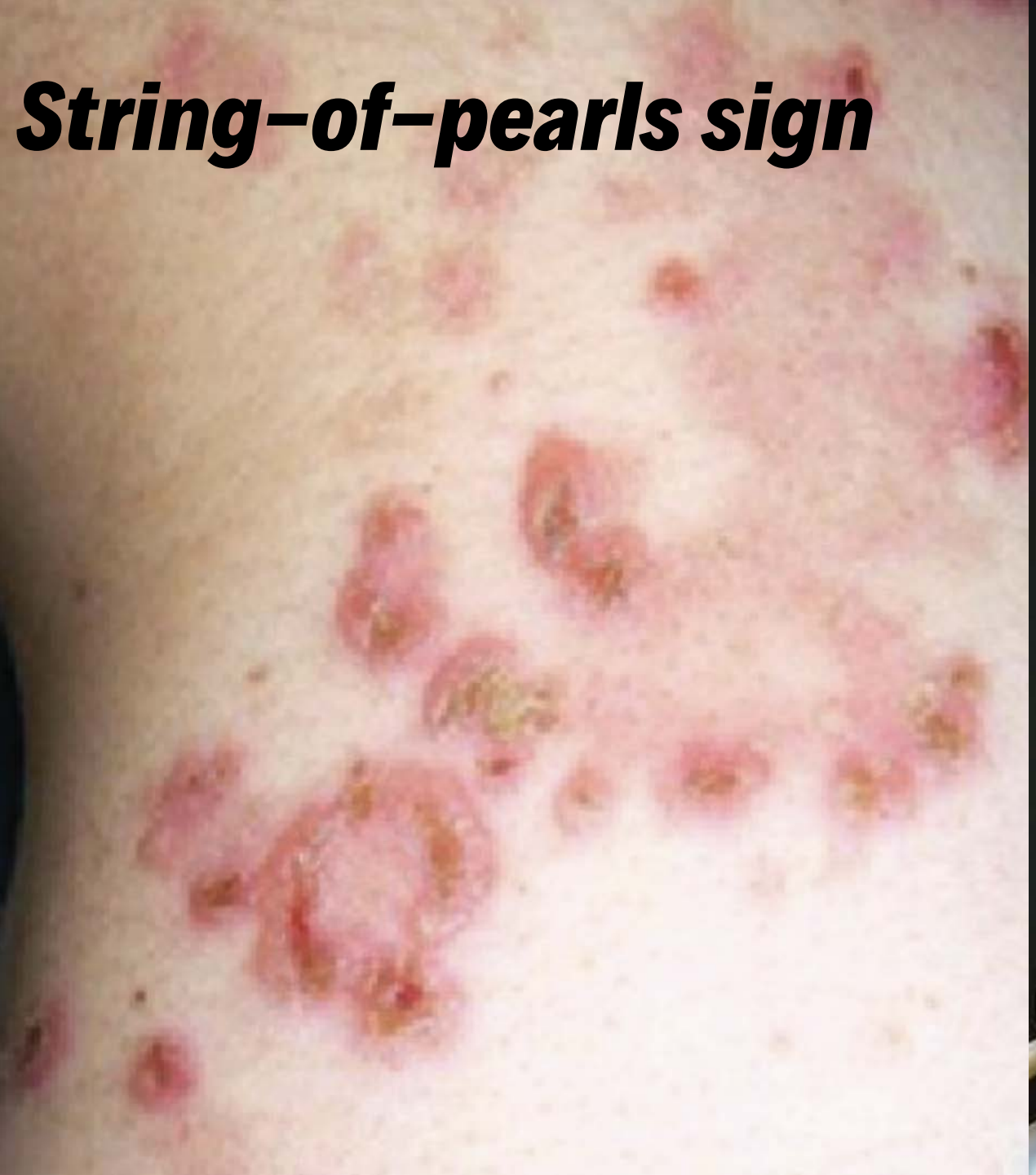
String-of-pearls sign



CFP April 2022, 68 (4) 266–268;

DIAGNOSING CBDC

- *Tense clear or hemorrhagic blisters 0.3–2.0 cm diameter*
- *Biopsy & immunofluorescence*

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CHRONIC BULLOUS DISEASE OF CHILDHOOD (CBDC)

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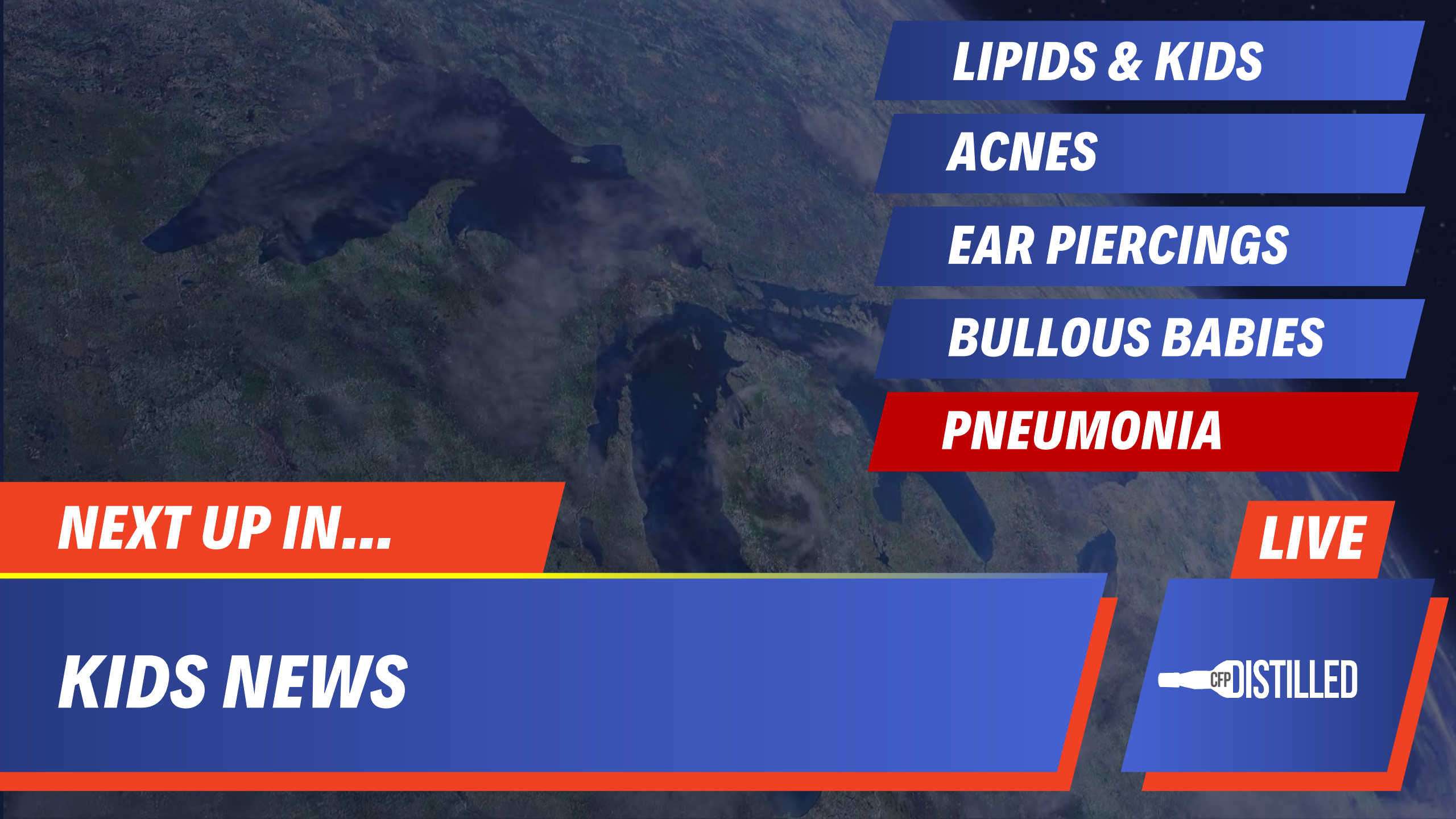
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Child Health Update

Antibiotic treatment duration for community-acquired pneumonia in children

Shalini Singla ACPR Kendra Sih PharmD Ran D. Goldman MD FRCPC

Abstract

Question A 4-year-old child was seen in our clinic with a clinical presentation consistent with community-acquired pneumonia (CAP). He was prescribed oral amoxicillin and a colleague asked about the duration of treatment. What is the current available evidence for treatment duration for uncomplicated CAP in an outpatient setting?

Answer Previously the recommended duration of antibiotic treatment of uncomplicated CAP was 10 days. Recent evidence from several randomized controlled trials suggests that a 3- to 5-day duration is noninferior to a longer treatment course. In an effort to prescribe the shortest effective duration of antibiotics to minimize the risk of antimicrobial resistance associated with prolonged antibiotic use, family physicians should offer 3 to 5 days of appropriate antibiotics and monitor the recovery of children with CAP.

Community-acquired pneumonia (CAP) is a common pediatric illness. The incidence of CAP has declined in high-income countries but is still a substantial burden to patients and health systems in low- and middle-income countries, partly due to lower childhood immunization rates.[1] In 2022 the World Health Organization reported that pneumonia accounts for 14% of all deaths in children younger than 5 years of age and 22% of all deaths in children aged 1 to 5 years.[2]

The most common viral cause of pediatric CAP is respiratory syncytial virus, followed by influenza viruses.[1,3] *Streptococcus pneumoniae* is the predominant cause of pediatric bacterial CAP.[1,3] Other bacterial causes include *Haemophilus influenzae* type b, *Staphylococcus aureus*, *Mycoplasma pneumoniae*, and *Chlamydia pneumoniae*.[1,3]

Five- and 10-day treatment courses

Three studies compared 5 and 10 days of treatment. A double-blind, randomized, placebo-controlled trial by researchers in Israel published in 2014 started comparing short (3-day) and long (10-day) durations of high-dose amoxicillin (80 mg/kg/day divided into 3 doses) for radiographically confirmed alveolar CAP in 108 febrile children with leukocytosis aged 6 to 59 months who were suitable for outpatient management.[6] The primary outcome, treatment failure, was described as "a situation assessed by the study physicians to be nonresponsive or deteriorating to the point that the study drug needed to be replaced, or if the patient was hospitalized due to deterioration in medical condition."[6] Statistically significant treatment failure rates early in the 3-day arm compared with the 10-day arm (40% vs 0%, respectively) led to a change in methods and the investigators evaluated 5 days versus 10 days of therapy. With no treatment failure in either arm, the authors concluded that 5 days of treatment was not inferior to 10 days of treatment of uncomplicated pneumonia. The relatively small number in this study, the strict criteria of the participants limit

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CAP IN KIDS

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ANTIBIOTICS: 3–5 DAYS, NOT 10

- *5 days noninferior to 10 days*
- *More recently: 3 days noninferior to 7 days**
- *Most studies: children > 6 months of age*

Multiple recent RCTs & systematic reviews
**n=814, JAMA 2021;326(17):1713–24*

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UNCOMPLICATED CAP IN KIDS

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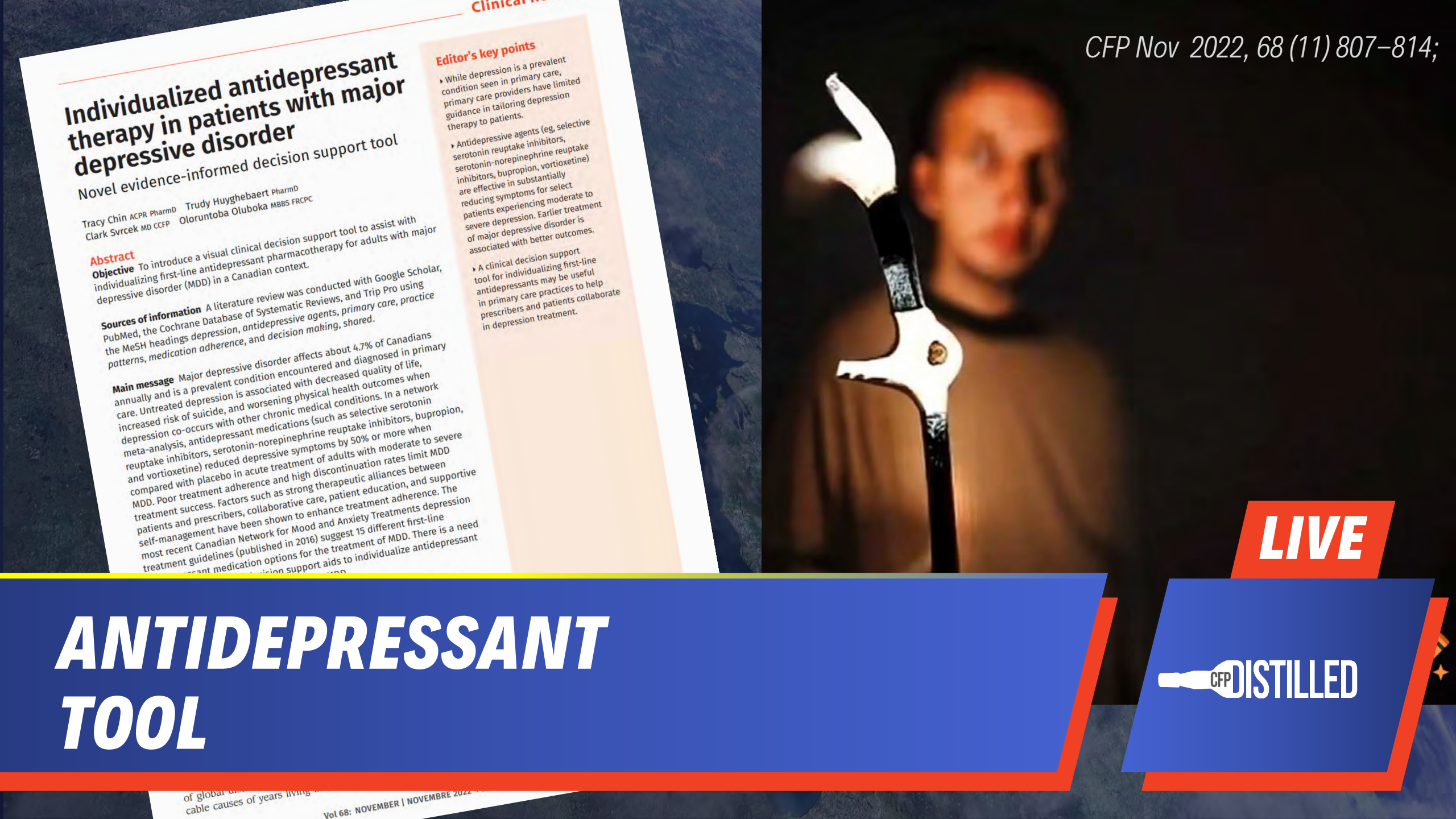
Individualized antidepressant therapy in patients with major depressive disorder
Novel evidence-informed decision support tool
Tracy Chin ACPR PharmD Trudy Huyghebaert PharmD
Clark Svrcek MD CCFP Oloruntoba Oluboka MBBS FRCPC
Abstract
Objective To introduce a visual clinical decision support tool to assist with individualizing first-line antidepressant pharmacotherapy for adults with major depressive disorder (MDD) in a Canadian context.
Sources of information A literature review was conducted with Google Scholar, PubMed, the Cochrane Database of Systematic Reviews, and Trip Pro using the MeSH headings depression, antidepressive agents, primary care, practice patterns, medication adherence, and decision making, shared.
Main message Major depressive disorder affects about 4.7% of Canadians annually and is a prevalent condition encountered and diagnosed in primary care. Untreated depression is associated with decreased quality of life, increased risk of suicide, and worsening physical health outcomes when depression co-occurs with other chronic medical conditions. In a network meta-analysis, antidepressant medications (such as selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, bupropion, and vortioxetine) reduced depressive symptoms by 50% or more when compared with placebo in acute treatment of adults with moderate to severe MDD. Poor treatment adherence and high discontinuation rates limit MDD treatment success. Factors such as strong therapeutic alliances between patients and prescribers, collaborative care, patient education, and supportive self-management have been shown to enhance treatment adherence. The most recent Canadian Network for Mood and Anxiety Treatments depression treatment guidelines (published in 2016) suggest 15 different first-line
Editor's key points
While depression is a prevalent condition seen in primary care, primary care providers have limited guidance in tailoring depression therapy to patients.
Antidepressive agents (eg, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, bupropion, vortioxetine) are effective in substantially reducing symptoms for select patients experiencing moderate to severe depression. Earlier treatment of major depressive disorder is associated with better outcomes.
A clinical decision support tool for individualizing first-line antidepressants may be useful in primary care practices to help prescribers and patients collaborate in depression treatment.
CFP Nov 2022, 68 (11) 807–814;
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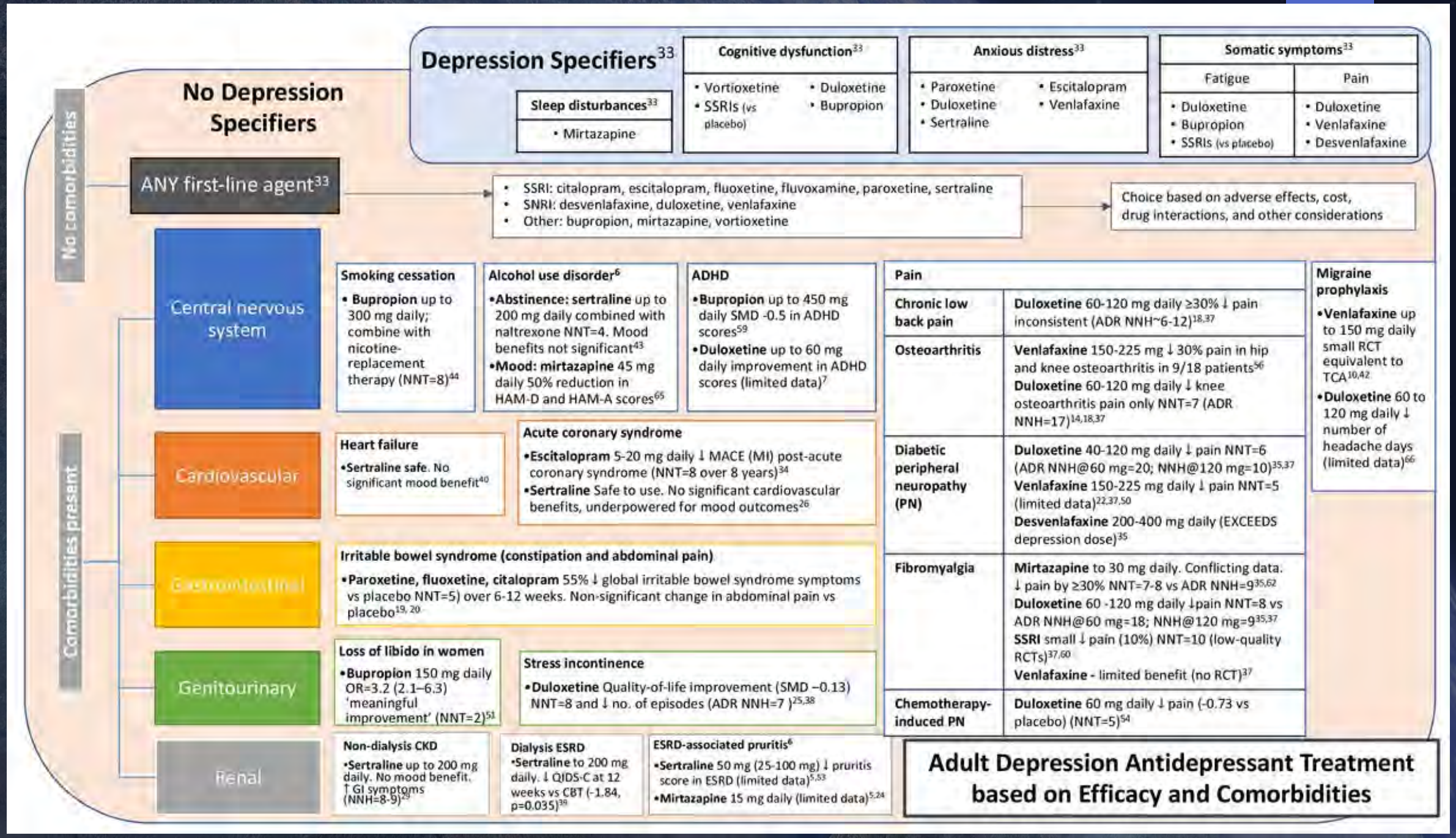
ANTIDEPRESSANT TOOL


No Depression Specifiers
Depression Specifiers[33]
Sleep disturbances[33]
• Mirtazapine
Cognitive dysfunction[33]
• Vortioxetine
• Duloxetine
• SSRIs (vs placebo)
• Bupropion
Anxious distress[33]
• Paroxetine
• Escitalopram
• Duloxetine
• Venlafaxine
• Sertraline
Somatic symptoms[33]
Fatigue
• Duloxetine
• Bupropion
• SSRIs (vs placebo)
Pain
• Duloxetine
• Venlafaxine
• Desvenlafaxine
No comorbidities
ANY first-line agent[33]
• SSRI: citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
• SNRI: desvenlafaxine, duloxetine, venlafaxine
• Other: bupropion, mirtazapine, vortioxetine
Choice based on adverse effects, cost, drug interactions, and other considerations
Comorbidities present
Central nervous system
Smoking cessation
• Bupropion up to 300 mg daily; combine with nicotine-replacement therapy (NNT=8)[44]
Alcohol use disorder[6]
•Abstinence: sertraline up to 200 mg daily combined with naltrexone NNT=4. Mood benefits not significant[43]
•Mood: mirtazapine 45 mg daily 50% reduction in HAM-D and HAM-A scores[65]
ADHD
•Bupropion up to 450 mg daily SMD -0.5 in ADHD scores[59]
•Duloxetine up to 60 mg daily improvement in ADHD scores (limited data)[7]
Cardiovascular
Heart failure
•Sertraline safe. No significant mood benefit[40]
Acute coronary syndrome
•Escitalopram 5-20 mg daily ↓ MACE (MI) post-acute coronary syndrome (NNT=8 over 8 years)[34]
•Sertraline Safe to use. No significant cardiovascular benefits, underpowered for mood outcomes[26]
Gastrointestinal
Irritable bowel syndrome (constipation and abdominal pain)
•Paroxetine, fluoxetine, citalopram 55% ↓ global irritable bowel syndrome symptoms vs placebo NNT=5) over 6-12 weeks. Non-significant change in abdominal pain vs placebo[19, 20]
Genitourinary
Loss of libido in women
•Bupropion 150 mg daily OR=3.2 (2.1–6.3) 'meaningful improvement' (NNT=2)[51]
Stress incontinence
•Duloxetine Quality-of-life improvement (SMD –0.13) NNT=8 and ↓ no. of episodes (ADR NNH=7)[25,38]
Renal
Non-dialysis CKD
•Sertraline up to 200 mg daily. No mood benefit. ↑ GI symptoms (NNH=8-9)[29]
Dialysis ESRD
•Sertraline to 200 mg daily. ↓ QIDS-C at 12 weeks vs CBT (-1.84, p=0.035)[39]
ESRD-associated pruritis[6]
•Sertraline 50 mg (25-100 mg) ↓ pruritis score in ESRD (limited data)[5,53]
•Mirtazapine 15 mg daily (limited data)[5,24]
Pain
Chronic low back pain
Duloxetine 60-120 mg daily ≥30% ↓ pain inconsistent (ADR NNH~6-12)[18,37]
Osteoarthritis
Venlafaxine 150-225 mg ↓ 30% pain in hip and knee osteoarthritis in 9/18 patients[56]
Duloxetine 60-120 mg daily ↓ knee osteoarthritis pain only NNT=7 (ADR NNH=17)[14,18,37]
Diabetic peripheral neuropathy (PN)
Duloxetine 40-120 mg daily ↓ pain NNT=6 (ADR NNH@60 mg=20; NNH@120 mg=10)[35,37]
Venlafaxine 150-225 mg daily ↓ pain NNT=5 (limited data)[22,37,50]
Desvenlafaxine 200-400 mg daily (EXCEEDS depression dose)[35]
Fibromyalgia
Mirtazapine to 30 mg daily. Conflicting data. ↓ pain by ≥30% NNT=7-8 vs ADR NNH=9[35,62]
Duloxetine 60 -120 mg daily ↓pain NNT=8 vs ADR NNH@60 mg=18; NNH@120 mg=9[35,37]
SSRI small ↓ pain (10%) NNT=10 (low-quality RCTs)[37,60]
Venlafaxine - limited benefit (no RCT)[37]
Chemotherapy-induced PN
Duloxetine 60 mg daily ↓ pain (-0.73 vs placebo) (NNT=5)[54]
Migraine prophylaxis
•Venlafaxine up to 150 mg daily small RCT equivalent to TCA[10,42]
•Duloxetine 60 to 120 mg daily ↓ number of headache days (limited data)[66]
Adult Depression Antidepressant Treatment based on Efficacy and Comorbidities


DEPRESSION TOOL
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Tools for Practice

Antihistamines for allergic rhinosinusitis

Betsy Thomas BScPharm Anthony Train MBChB MSc CCFP G. Michael Allan MD CCFP FCFP

Clinical question

Do oral antihistamines (AHs) improve symptoms in adults with allergic rhinosinusitis?

Bottom line

Oral AHs reduce rhinosinusitis symptoms by 10% to 30% versus placebo over 2 to 12 weeks. Individual AHs appear to have comparable efficacy. More patients attain moderate improvement or better with intranasal corticosteroids (ICs) (about 80%) versus AHs (about 60%). There appear to be no meaningful differences between AHs and leukotriene receptor antagonists or when adding AHs to IC use.

Evidence

Results were statistically significant unless noted.

- Antihistamines versus placebo over 2 to 12 weeks:
  - -Systematic review (7 RCTs, 1218 patients)[1] found that for patient-rated nasal obstruction scores (scale 0 to 3), baseline=1.65; placebo improved symptoms 16% and AHs 48%.
  - -Systematic review (5 RCTs, 3329 patients)[2] of bilastine (newer AH) found total symptom score effect size=0.28, similar to improving symptoms 10% to 16% over placebo.[3]
- ines versus other AHs:
  - ed no statistical or clinical

- Estimated cost for 30-day supply: cetirizine 10 mg, desloratadine 5 mg, or fexofenadine 120 mg, $25; bilastine 20 mg, $45; mometasone 50 µg or beclomethasone 50 µg, $25; fluticasone 50 µg, $40.[12]

Implementation

Antihistamines have comparable efficacy, so choice should be based on cost and adverse event profile. Patients presenting in primary care typically have moderate to severe rhinosinusitis symptoms and more patients are likely to benefit from nasal steroids versus AHs.[13] Improvement with nasal steroids may take several days and full effect can take up to 2 weeks.[13]

Betsy Thomas is Clinical Evidence Expert at the College of Family Physicians of Canada. **Dr Anthony Train** is Assistant Professor in the Department of Family Medicine at Queen's University in Kingston, Ont. **Dr G. Michael Allan** is Director of Programs and Practice Support at the College of Family Physicians of Canada.

Competing interests

None declared

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- *Bilastine: Less sedating (3% vs. 7% cetirizine), higher cost*
- *All have similar efficacy*

**1 RCT, n=162. **4 systematic reviews of 5 RCTs*

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Reducing death rattle at the end of life

Jen Potter MD CCFP Christina S. Korownyk MD CCFP

Clinical question

Can medications reduce the incidence of terminal respiratory secretions (death rattle) at the end of life?

Bottom line

Best evidence supports prophylactic administration of scopolamine butylbromide (Buscopan, hyoscine butylbromide) in patients close to death but without death rattle, which reduces the number who develop death rattle (13% vs 27% with placebo). Evidence supporting treatment of death rattle once it has begun is less clear, with no evidence that one anti-muscarinic is clearly superior to another. There is no evidence that treatment of death rattle improves patient comfort. It may, however, reduce the distress of people at bedside. Treatment decisions should be guided by conversations with family or caregivers.

Evidence

Prophylaxis

- In 1 double-blind RCT,[1] 162 hospice patients in the dying phase (according to a multidisciplinary team) without death rattle were given scopolamine butylbromide, 20 mg subcutaneously 4 times daily, or placebo.
  - Development of death rattle (score of 2 or 3 on a 3-point scale, higher scores indicating worse condition) at any point prior to death: 13% versus 27% (placebo); number needed to treat of 8.
  - Adverse events (including restlessness, dry mouth, or urinary retention): no difference.
- One non-blinded RCT[2] with 132 adults close to death but without death rattle examined prophylaxis versus treatment at onset of death rattle with scopolamine butylbromide 20 mg subcutaneously then 60 mg every 24 hours: death rattle if treatment was initi- 6% of patients

Context

- *Death rattle* is defined as noisy breathing caused by mucus in the upper respiratory tract.
  - It occurs in 12% to 80% of patients in the final 3 days of life.[7]
  - It may not distress patients; however, it may be distressing to family and caregivers.[1]
- Nonpharmacologic measures include physical repositioning, although evidence to support this is lacking.[5]
- Scopolamine butylbromide (Buscopan) is available subcutaneously or orally in Canada.
  - Scopolamine hydrobromide is different and can cause central nervous system effects.[8]

Implementation

While glycopyrronium is commonly used for death rattle, there is little evidence of efficacy or tolerability. Prophylaxis with scopolamine butylbromide appears more effective than treatment once death rattle is established, so it is reasonable to consider in a patient's dying phase. It is important to examine the reasons treatment is being explored, including patient and caregiver distress. Consideration of alternative supportive measures including reassurance and management of other symptoms (eg, pain or dyspnea) may provide greater comfort.

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Competing interests

None declared

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REDUCING DEATH RATTLE

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HYOSCINE STOPS RATTLE

- *Prophylaxis: 13% develop (vs. 27% with placebo)**
- *After it presents:*
  *Scopolamine = atropine = octreotide = placebo***

**1 RCT, n=162. ***4 systematic reviews of 5 RCTs*

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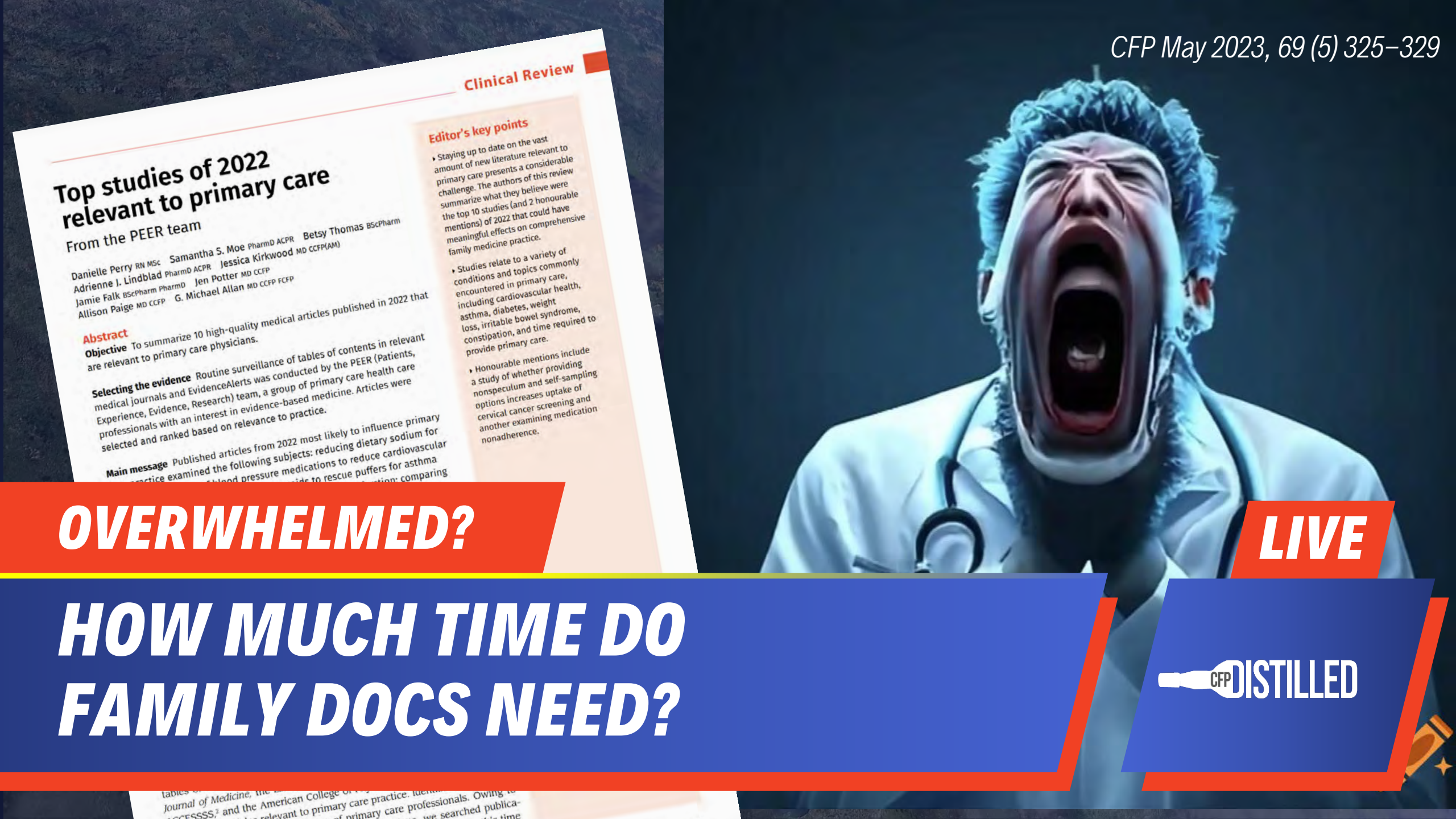

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