

Primary care update

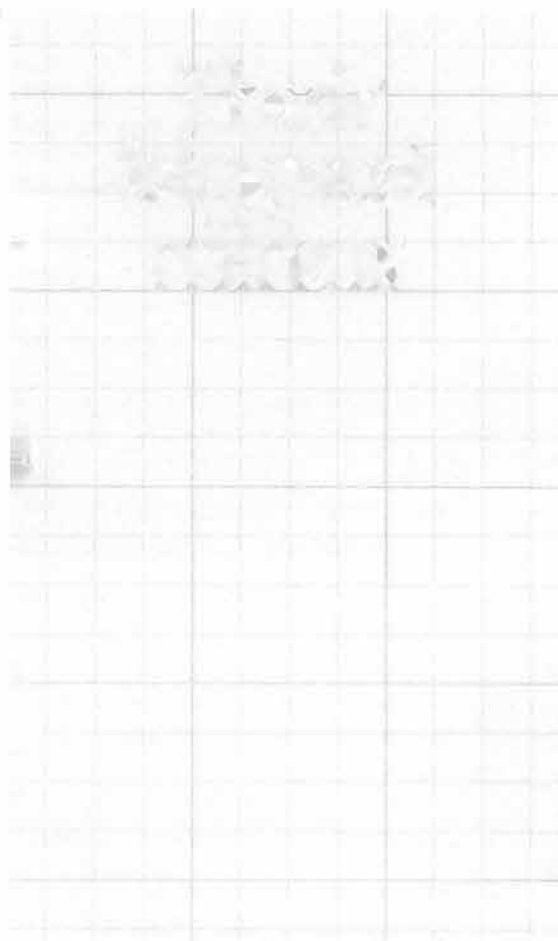
UNSTABLE ANGINA: CATHETERIZATION OR STRESS TESTS

Patients with clinically diagnosed unstable angina should be hospitalized, treated with antiplatelet drugs and heparin, stabilized, and then catheterized, regardless of whether or not electrocardiography shows ST changes. Stress tests are not recommended for these

patients because of the possibility that the exertion could induce myocardial infarction.

Catheterization determines the management for a majority of unstable angina cases. Between 10% and 20% of these patients have left main coronary artery disease; if not diagnosed and revascularized, 3-year survival is decreased. Approximately one third of the cases have extensive three-vessel disease which can be improved by surgical revascularization. For about 20% of cases, catheterization demonstrates the absence of coronary artery disease, a finding which can prevent this subgroup of patients from being subjected to un-

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necessary medications, high-risk insurance rates, and the stigma associated with heart disease.

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MORPHINE FOR CANCER PAIN: AVOIDING PROBLEMS, DISPELLING MYTHS

Provided the principles of morphine use for management of cancer pain are stringently adhered to, the side effects associated with its use are few, but may include dry mouth, sedation, constipation, nausea, myoclonus, and respiratory depression. Nausea is uncommon and occurs more often in women than in men. Myoclonus is a very common unwanted effect, but it is mild and is not related to any progression to seizure activity. Respiratory depression is rare. Constipation is

best managed preventively: a regular laxative regimen should be started at the same time morphine is first prescribed. The majority of patients who develop opiate-induced constipation can be managed adequately by regular use of a stool softener combined with an osmotic laxative such as Milk of Magnesia.

Much concern is expressed by physicians and nursing staff about tolerance, dependence, and addiction. Tolerance, a rapid and continuous increase in drug dosing despite a static or sometimes falling therapeutic response, is unusual in this patient population, provided adequate doses of medication are employed and the medication is given correctly. A distinction must be made between the problems of physical dependence and addiction. Addiction refers to drug-seeking behavior, diversion of prescriptions, theft, etc. This is rare in the cancer patient and should not be a barrier to adequate and appropriate management of severe cancer pain with opiates. Physical dependence occurs in all patients who are placed on opiates long-term. Its only

practical import is that, if another intervention allows pain to be relieved and therefore morphine to be discontinued, it is important to reduce the dose in a step-wise fashion, analogous to that employed for corticosteroid withdrawal to avoid problems with withdrawal syndrome. Even if withdrawal syndrome occurs from oral opiates, it is generally mild and not of the type seen in the addict population.

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ACUTE SINUSITIS: IMPACT AND MANAGEMENT

Sinusitis recently surpassed arthritis as the nation's most prevalent chronic disease: 31 million Americans are currently afflicted, according to the Center for Disease Statistics. While the vast majority of

sinusitis cases are self-limiting, the disease has a large impact on the nation's health care bill. Sinusitis was the reason for 16 million doctor visits in 1989, 90% of which were to primary care physicians. In fact, 33% to 50% of all visits to primary care physicians are for upper respiratory infections and their sequelae, and 0.5% to 5% of these are associated with sinusitis. Further, \$150 million is spent on cold remedies annually, and the amount seems to be growing. Antihistamine purchases, which account for \$100 million of the total, increased by 26% from 1988 to 1989.

Acute sinusitis, which can affect any of the sinuses (frontal, maxillary, ethmoidal, or sphenoidal), usually originates from an upper respiratory infection by *Streptococcus* or *Hemophilus* organisms. Therefore, the recommended management should include application of antibiotics, topical and systemic decongestants, and mucolytic agents. The antibiotic of choice is amoxicillin, given in doses of 500 mg three times daily for 14 to 21 days. Topical decongestants should be used for

periods of not more than 5 days due to possible rebound effects. Contrary to popular belief, antihistamines should be avoided as they tend to thicken secretions, thus increasing blockage and inhibiting drainage.

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OSTEOPOROSIS: WHEN TO USE CALCITONIN

Calcitonin is the treatment of choice for specific groups of osteoporotic patients. Because of its unique analgesic effect, calcitonin is recommended for patients who have significant pain that cannot be controlled by other methods. Calcitonin has also been shown to be beneficial in patients with steroid-induced osteoporosis. In studies monitoring patients during a 6-month period of steroid treatment, salmon calcitonin injections were found to prevent bone resorption.

Prior to beginning calcitonin treatment, tolerance testing should be conducted to eliminate the risk for allergic reactions. The typical management plan calls for the injection of 50 to 100 units daily or every other day. When used as an analgesic, the injections should be administered for a 2-week trial period, after which, if no improvement is apparent, treatment should be discontinued. If a favorable response is noted within 2 weeks, treatment should be continued for several more weeks, then reduced to three times per week and gradually discontinued over the next few months. At that point, the pain has often been effectively controlled; if not, it is sometimes necessary to resume the drug regimen. When used to treat osteoporosis, treatment should be conducted for at least 2 or 3 years. No trial period is necessary since the drug's efficacy for this purpose may not be readily apparent. Assessing bone mineral density is the best monitor of efficacy.

No significant toxicity associated with long-term use of calcitonin has been reported since the agent was first introduced 20 years ago. Unlike other analgesics, the drug does not induce central nervous system reactions. Nausea is the only commonly experienced side effect. Antiemetics counteract the effect. An intranasal form of calcitonin currently under investigation appears to produce an even lower incidence of side effects.

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**THE
FIRST
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SYMPOSIUM ON
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RECONSTRUCTION**

Stouffer Tower City Plaza Hotel
August 23-27, 1991

This Symposium will be prepared by staff members of the Department of Otolaryngology and Communicative Disorders at The Cleveland Clinic Foundation together with a very distinguished international and national faculty and invited guests. An overview and tutorial precede the actual symposium in an attempt to cover the etiology, prevalence, pathophysiology and management of laryngotracheal stenosis.

The sessions of invited papers will provide the state of the art assessments of the various challenges that confront those involved in the management of stenotic lesions in the airway. Panel discussions will attempt to provide answers to controversial dilemmas. Free paper sessions and expansive poster sessions will complete the program.

**FOR FURTHER INFORMATION
REGARDING THIS SYMPOSIUM, CONTACT:**

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