

OPHTHALMOLOGY

Age-Related Macular Degeneration in Latinos

The Los Angeles Latino Eye Study (LALES) revealed a number of risk factors for age-related macular degeneration (AMD). Older age, increased pulse pressure, diabetes, and male gender were associated with early AMD. Older age and a current smoking habit were associated with higher risk of progression (smoking nearly tripled the risk). Those findings were consistent with results from other population-based longitudinal studies. However, in this analysis, pulse pressure emerged as the most important modifiable risk factor in this cohort.

Fundus photographs gradable for AMD lesions were available for 3,931 of the 4,658 participants in the 4-year follow-up study. Of those participants, 3,908 had gradable fundus photographs in at least 1 eye from their baseline examination. By year 4, 100 participants (2.5%) had AMD (92 early and 8 late AMD). In 87 patients, AMD had progressed. The researchers, commenting on the relatively low rate of progression, note that a previous analysis from LALES suggested a low prevalence among Latinos of the genetic risk factor CFH Tyr402 polymorphism, which affects progression.

The researchers, from the University of Southern California in Los Angeles, and the University of Wisconsin in Madison, say there's a relative lack of population-based data on eye health in Latinos, and the factors associated with AMD incidence and progression were "largely unexplored" before their study. However, data from LALES showed the incidence of early and late AMD is lower among Latinos than in other populations, which made it important to also find out why. The

researchers suggest not only further research, but also interventions aimed at the specific risk factors, such as high blood pressure, smoking, and diabetes. Diabetes, in particular, requires more attention, they add, because diagnosed diabetes is 1.7 times more likely in Latinos than in non-Hispanic whites. Timely prevention, diagnosis, and management of diabetes will also help reduce the risk of ocular disease.

Source: *Am J Ophthalmol.* 2011;152(3):385-395.
doi:10.1016/j.ajo.2011.02.025.

ONCOLOGY

Breast Cancer Guidelines in Theory and Practice

In November 2009, in an effort to minimize screening harm while preserving maximal benefit, the U.S. Preventative Services Task Force (USPSTF) announced revised evidence-based guidelines for breast cancer screening. The major changes included raising the age of first mammogram from 40 to 50 years of age and reducing frequency of mammograms from annually to every 2 years. But when researchers from the University of Connecticut in Storrs, New York Presbyterian Hospital-Cornell University in New York City, and New York Medical College in Valhalla surveyed 40 gynecologic care providers, they found they didn't always agree with the guidelines.

For instance, when asked to finish the statement, "Women between the age of 50 and 74 [years] are recommended to have screening mammography..." 54% responded with "every year."

Notably, while 93% of the respondents said they were aware of the guidelines, only 17 (42%) said the guidelines were applicable to their patient populations.

One possible explanation for the mismatch, the researchers suggest, is that the USPSTF guidelines aren't the only ones that have been issued. The American Congress of Obstetricians and Gynecologists (ACOG) guidelines, for instance, recommend screening every 1 to 2 years beginning at age 40. Another possibility, the researchers say, is that the survey respondents answered the survey according to how they practiced, not according to what the guidelines state. But, the issue actually may be more a matter of preference—only 20% of the respondents said they "somewhat" or "completely" agreed with the revisions.

Source: *Am J Obstet Gynecol.* 2011;205:201.e1-201.e5. doi:10.1016/j.ajog.2011.04.025.

OBESITY

Choosing Between Bariatric Surgeries

In the first randomized study comparing gastric bypass (GB) with duodenal switch (DS) surgery, DS surgery led to greater weight loss and greater reductions in total and low-density lipoprotein (LDL) cholesterol—but more serious adverse events.

Of the 60 participants, 58 completed the 2-year study, conducted at Sahlgrenska University Hospital in Sweden and Oslo University Hospital Aker in Norway. At baseline, patients had a body mass index (BMI) between 50 kg/m² and 60 kg/m² and were randomly assigned to 1 of the 2 procedures.

After 2 years, the GB patients had a mean reduction in BMI of 17.3 kg/m², compared with 24.8 kg/m² in the DS group. The GB group lost a mean of 50.6 kg compared with 73.5 kg in the DS group. At the end of the 2-year follow-up, 8 of 31 GB patients (26%) had a BMI of 40 kg/m² or higher vs none of

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CLINICAL DIGEST

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the 27 in the DS group. However, the mean percentage of weight lost as fat-free mass did not differ between the groups (about 24% in each).

Both procedures were associated with significant reductions in waist and hip circumference and sagittal diameter, but all reductions were greater in the DS patients.

Cardiovascular markers improved in both groups, but more so in the DS patients. Total cholesterol concentration dropped by 0.24 mmol/L after GB vs 1.07 mmol/L after duodenal switch. LDL cholesterol declined by 0.26 mmol/L in the GB group and 0.78 mmol/L in the DS group. Both groups showed significant reductions in mean triglyceride concentrations and significant increases in high-density lipoprotein (HDL) cholesterol.

Blood pressure, fasting levels of glucose and insulin, and C-reactive protein all fell significantly, with no between-group differences.

However, the marked contrast in weight loss did not translate to greater improvements in quality of life for the

DS patients. Duodenal switch is more difficult to perform by laparoscopy, the researchers say, and has been associated with a higher mortality rate than laparoscopic gastric bypass. Significantly more DS patients had surgery-related adverse events than GB patients: 62% vs 32%, respectively. Twelve DS patients (41%) and 9 GB patients (29%) had long-term effects (longer than 30 days postsurgery). One DS patient experienced acute hepatic failure (despite not drinking alcohol to excess), pneumonia, and malnutrition after laparoscopic surgery for bile duct stones. Two other DS participants required parenteral nutrition and a protein-enriched diet for malnutrition. Other adverse events in this group included traumatic subarachnoid hemorrhage, meningitis (complicated by gangrene), and peritonitis. By contrast, the main adverse events in the GB group were vomiting, pain, diarrhea, gallstones, and herniation.

Both surgeries were ultimately associated with significant improvements, including bodily pain. But the re-

searchers suggest cautioning patients who are considering GB that, even though they are likely to experience clinically important health benefits, they may expect to still be severely obese after surgery. And, because DS is often reserved for patients with a BMI greater than 50 kg/m², the researchers say, balancing the health benefits and safety of this operation to those of other procedures is important. The researchers advise restricting DS surgery to well-informed, super-obese patients who are likely to adhere to clinical follow-up. They also suggest monitoring patients even more closely after DS than GB because of the greater risk of micronutrient deficiencies. ●

Source: *Ann Intern Med.* 2011;155(5):281-291.

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