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The observations of someone close to the patient may be more accurate than any screening test you could give.

Forget the mental status test—and learn to listen

My wife was diagnosed with Alzheimer's disease (AD) at age 63. Unfortunately, her AD went misdiagnosed for several years while I repeatedly tried to convince her doctors that she was experiencing dementia. For 3 years, doctors administered the Mini-Mental State Exam (MMSE) and other cognitive tests, but she consistently did very well (on one occasion scoring 29 out of a possible 30 on the same day that she couldn't remember our granddaughters' names). An MRI of her brain showed no definitive signs of AD. Thus, she was treated for stress, anxiety, and depression, although I told both our primary care physician (PCP) and a neurologist that her symptoms couldn't possibly be due to any of these conditions.

I documented my wife's behaviors in weekly logs and brought copies to each visit, but invariably my notes went unread or were quickly dismissed. When I told the PCP I thought the medications prescribed by the neurologist weren't working because she was declining further, he deferred to the specialist, who advised us to "stay the course." Finally, I convinced my wife to see a psychiatrist affiliated with a major medical center who requested copies of my logs even before our first visit.

At that visit, the psychiatrist interviewed us at length, reviewed previous tests, and administered his own cognitive, physical, and neurological tests. He then ordered a new battery of tests and referred us to his facility's AD center, where my wife finally received a diagnosis of early-onset Alzheimer's.

Doctors can improve their chance of accurate diagnosis simply by listening to the spouse or significant other. One recent study found that the AD8, an 8-question, 2-minute screening test given to a close friend or family member, was superior to conventional testing in its ability to detect signs of early dementia.¹

Although doctors can't identify the cause of AD or offer hope for a cure, early diagnosis is important. The sooner the patient starts taking



medication designed to help slow the degenerative progression, the more effective the drugs may be.

So please, doctors, if a family member or loved one reports worrisome symptoms of possible dementia, listen carefully. The observations of someone close to the patient just may be more accurate than any screening test you could give.

Allan Vann
Commack, NY

1. Galvin JE, Fagan AM, Holtzman DM, et al. Relationship of dementia screening tests with biomarkers of Alzheimer's disease. *Brain*. 2010;133:3290-3300.

Topical diclofenac for sprains?

These doctors say No

"An alternative to oral NSAIDs for acute musculoskeletal injuries," (PURLs, *J Fam Pract*. 2011;60:147-148) promotes an unreasonable conclusion. The Cochrane review on which it is based found a 50% response rate to topical diclofenac for ankle sprains, compared with a 25% response to placebo. (A response was defined as $\geq 50\%$ reduction in pain.) The authors of the Cochrane review seem to think this is adequate, and the authors of this PURL apparently agree.

First, they overstate the benefit. If we consider that 1 in 4 patients respond to placebo, we find that only 1 in 4 patients actually have what the authors describe as an adequate response to topical diclofenac. That still means that half the patients I see for ankle sprain could be calling at 11:00 PM to complain about inadequate pain relief.

Second, the Cochrane reviewers did not use an active control group with oral NSAIDs, leaving us to guess whether oral NSAIDs are equally effective, worse, or better than topical agents. The great majority of people I treat for ankle sprains obtain adequate pain relief with oral therapy. Studies have compared topical and oral NSAIDs, but the authors make no mention of these comparisons.

I trust and rely on the Cochrane reviews, but they are not the word of God. This review did not provide useful information. The space

would have been better devoted to a topic I can put into practice.

Dean M. Center, MD
Bozeman, MT

I find it difficult to believe that these ivory tower researchers used topical diclofenac as their base. I've used topical agents for acute musculoskeletal pain for 40 years, costing one-tenth (or less) of the price of diclofenac. Only a few patients have complained of skin reactions. For more severe cases, capsaicin is a good choice; otherwise, a methyl salicylate product is very effective, at a concentration of 30% or more. Both are available as generics and do not require a prescription.

Robert Migliorino, DO
Lake Preston, SD

The authors respond:

We appreciate the issues raised by the letter writers. Dr. Center notes that there are few head-to-head trials with other therapy options, such as oral NSAIDs or acetaminophen. We agree. This Cochrane review demonstrates another possible option for pain relief for patients who cannot tolerate oral NSAIDs or prefer not to take them. The body of literature comparing topical to oral NSAIDs is small, but we could not find any high-quality evidence to suggest that oral NSAIDs are more effective.

Dr. Center also questions the clinical utility of a medication that must be given to 4 patients in order for 1 to have a 50% reduction in pain (number needed to treat [NNT]=4). The NNT for topical NSAIDs is about the same.¹ For acute musculoskeletal injuries, 1 patient in 4 will respond to placebo, 1 in 4 will respond to active topical or oral therapy, and 2 in 4 will fail treatment. Whether these response rates are acceptable is an individual clinical decision to be made with the patient. We believe they are acceptable to most patients.

We thank Dr. Migliorino for bringing to light other topical pain medications. Diclofenac is the only topical NSAID available in the United States, which is why we chose to high-



light it. The Cochrane review did not include salicylates because they are no longer classified as topical NSAIDs, and capsaicin was not included as it is not an NSAID. Both may very well offer pain relief.

The purpose of PURLs (Priority Updates from the Research Literature) is to identify and disseminate evidence that should change the practice of family medicine.

We believe that this Cochrane review demonstrates that topical NSAIDs are effective options for acute musculoskeletal injuries and that many primary care physicians would be unfamiliar with this option.

Nna V. Rogers, MD
Kate Rowland, MD
Chicago

1. Paolini, J, Orchard, J. The use of therapeutic medications for soft-tissue injuries in sports medicine. *Med J Australia*. 2005;183:384-388.

It's too soon to recommend probiotics for colic

The authors of "Colicky baby? Here's a surprising remedy" (PURLs, *J Fam Pract*. 2011;60:34-36) suggest that probiotics are a remedy for infantile colic. The study was funded by producers of probiotics, but the rigorous study design is deemed to make bias unlikely, leading the authors to recommend a change in practice. We very much hope this will be a big step forward, but feel the need to air our concerns: namely, that probiotics (cost: about \$40 per month) may substitute for parental love (cost: \$0 per lifetime). It's a huge marketing opportunity, as 10% to 25% of infants have infantile colic.¹ We are not fully convinced of the benefits.

To start with, the term "infantile colic" suggests an abdominal cause, although this "cause" is not mentioned in published criteria.² It has been suggested that infantile colic may simply lie at the upper end of a normal distribution.³

Related to the treatment, no adverse events were reported, nor any differences between the placebo and probiotics groups in frequency of stools or incidence of regurgitation or constipation.

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> I've used topical agents for acute musculoskeletal pain for 40 years, costing one-tenth (or less) of the price of diclofenac.

Then why did the babies cry less? The answer seems obvious: because they have less pain. But why do babies have less pain from having an enhanced intestinal flora vs a natural one, while having no change in gastrointestinal functions? Has nature gone astray? Could there have been factors that made mothers feel the difference between the treatment and the placebo groups, such as side effects that were not reported and that may have enhanced the placebo effect? (Notably, one study found a substantial placebo effect on colic.⁴) Babies are extremely emotionally symbiotic with their mothers, and thereby very prone to “suggestivity” coming from the mother (or father).

We certainly do not mean to suggest that colic is related to poor parenting skills. We do, however, see a need for more investigations before turning the prescription of probiotics for infantile colic into a clinical guideline.

Jean-Luc Mommaerts, MD, MSc
Dirk Devroey, MD, PhD
Brussels, Belgium

1. Roberts DM, Ostapchuk M, O'Brien JG. Infantile colic. *Am Fam Physician*. 2004;70:735-740.

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- Savino F, Cordisco L, Tarasco V, et al. *Lactobacillus reuteri* DSM 17938 in infantile colic: a randomized, double-blind, placebo-controlled trial. *Pediatrics*. 2010;126:e526-e533.
- Metcalf TJ, Irons TG, Sher LD, et al. Simethicone in the treatment of infant colic: a randomized, placebo-controlled multicenter trial. *Pediatrics*. 1994;94:29-34.

The authors respond:

Thank you for your letter and comments. We wholeheartedly agree that nothing can replace a parent's love and patience in dealing with colic.

The study was randomized, which decreases the risks of bias that you describe. You correctly point out that placebo was also an effective treatment for colic, although not as effective as the intervention. Nevertheless, we think that this was a well-done study offering a new treatment for colic that many physicians may not have previously considered.

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