

Culture clash? Rural docs weigh in

I would love to have been the proverbial mouse in the corner, listening to Dr. Hickner's conversation with Steve, the rural physician whom he met with the night after Obama's reelection (Postelection culture clash? [Editorial] *J Fam Pract.* 2012;61:717).

As a rural solo physician for 22 years, I very likely am a kindred spirit of Steve's. I also have little doubt that Dr. Hickner and I would not see eye to eye on the political scene, and more specifically, on the health care mandates coming at us. How in the world can anyone think that a health care bill that has income taxes, Medicare benefit taxes, and medical equipment fees buried within it is honest, forthright, and justifiable legislation?

Yes, medicine/health insurance is in need of real reform. I simply do not see bigger, more controlling, and more intrusive government as the answer, nor do I think that the best outcomes will come from the federal government's excessively complex and overreaching involvement. The fact that after decades of opportunity to perfect it, Medicare is still a highly complex, ineffective, and insolvent mess (and a political football) should be enough proof for anyone.

With all due respect, Steve should remain firm in his convictions—with the knowledge that, unlike Dr. Hickner's huge medical establishment, his community needs him.

Jeff Taber, MD
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I'm glad Dr. Hickner recognizes that political diversity need not compromise the commitment to patient care. But I'm sad that in recounting his discussion with Steve, he failed to comment on an even bigger culture clash—the one between rural and metropolitan health care.

Here it is, in a nutshell: Steve is out in the hinterlands, where physician shortages are a constant, yet Dr. Hickner wants to recruit him to be a pseudo-internist in a system



where you can't swing a stick without hitting 2 subspecialists. Wouldn't it be better for patient care to let Steve maintain the rapport he has with his patients and have the Cleveland Clinic ship some of its specialists out to Steve's "shop" a couple of days a month?

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Postcoital vomiting after taking sildenafil?

When you think of sildenafil citrate for the treatment of erectile dysfunction (ED), what adverse effects come to mind? Chances are you think of some of the most common adverse reactions, such as headache (16%), flushing (10%), and dyspepsia (7%), with the latter more common (17%) at higher doses.¹ Or perhaps you think of diarrhea (3%) or maybe even dizziness (2%). But chances are, you don't think of vomiting, which is reported to occur in <2% of patients.¹ In fact, an OVID search for the terms PDE5 inhibitors and vomiting revealed no reports of postcoital emesis. In the case we report here, however, postcoital vomiting secondary to sildenafil use did occur.

Our patient, a 43-year-old African-American man with a 23-year history of diabetes and hypertension, sought help for ED. His medications included insulin 70/30 and irbesartan/hydrochlorothiazide (Avalide) 150/12.5 mg daily, due to a history of ACE inhibitor-induced cough. He denied the use of tobacco and recreational drugs but admitted to consuming 6 to 10 beers on Friday nights. He followed no special diet or exercise regimen. A review of systems was negative except for the ED, presumed to be organic as the physical exam was unrevealing.

The patient was not using nitrates and had no known contraindications for sildenafil, and therapy was initiated at 50 mg as needed prior to sexual activity. On follow-up, he reported an acceptable erectile response but noted the onset of postcoital emesis. He denied associated nausea, but reported that

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Yes, medicine and health insurance are in need of real reform, but bigger, more controlling, and more intrusive government is not the answer.

on multiple occasions, emesis occurred soon after ejaculation, typically occurring about 90 minutes after ingestion of sildenafil.

The adverse effect profile of sildenafil may be divided into vasodilator effects and enzymatic inhibitor effects.² It is postulated that an emetic response may be associated with PDE4 inhibitors secondary to release of mediators 5-HT, substance P, and noradrenaline analogous to presynaptic α_2 -adrenoceptor inhibition.³

A study by Robichaud et al showed that administration of PDE4 inhibitors reduced the duration of anesthesia induced by a combination of xylazine and ketamine—a correlate of emesis in nonvomiting species (rodents).³ But it is not known if inhibition of PDE4 promotes emesis in humans or if a similar effect occurs with PDE5 inhibitors like sildenafil.^{3,4} Mild cross-reactivity of sildenafil with PDE6 (present in the retina) explains the visual disturbances associated with the drug (changes in color perception, blurry vision, and light sensitivity)⁵ and lends further credibility to possible cross-reactivity between PDE4 and PDE5.

Emesis in the absence of nausea or other gastrointestinal (GI) symptoms supports a drug-related effect, rather than a complication associated with type 2 diabetes or binge drinking. The patient denied symptoms of fullness, upper abdominal pain, or reduced hunger, all of which correlate better with delayed gastric emptying associated with diabetic gastroparesis than nausea or vomiting.⁵

The patient's weekly consumption of beer meets the criteria for binge drinking defined by the National Institute of Alcohol Abuse and Alcoholism;⁶ however, emesis associated with

ingestion of sildenafil occurred independent of alcohol ingestion, according to our patient.

The patient was advised to try sildenafil both with and without food to determine if either scenario would ameliorate symptoms of vomiting, and to reduce the dosage to 25 mg. Since he now has another health care team, we do not know whether he tried again with sildenafil or another PDE5 inhibitor.

Another case in the literature struck us as remarkably similar. A case report published in 2002 described a 79-year-old man who experienced vestibular symptoms 2 hours after taking sildenafil for the first time, including horizontal nystagmus with rotator components and vomiting.² The similar time frame as our patient's complaints also indicates a drug-related phenomenon. The observation of vomiting appears to be unique in the literature and supports its inclusion in published reports that include the long list of sildenafil's potential adverse effects.

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