



EDITOR'S CORNER

Multiple Sclerosis (August 2005)

Q: In Appendix 5, a treatment suggested for tremor is "INH (inhibace)." INH is isoniazid and Inhibace7 is cilazapril. I am not familiar with either medication as a treatment for tremor, so please clarify.

A: Tremor occurs in about in about 25–60% of MS patients, and isoniazid (INH) *is* one potential treatment option. Evidence for its effectiveness typically consists of case reports, although small RCTs have been done:¹

- One study found a reduction in tremor in six of eight patients and a functional improvement in four patients.²
- Another study observed a reduction in tremor in all six patients but no functional improvement was noted.³

Doses of isoniazid for MS-related tremor are very high (up to 1200 mg/day) and are associated with GI distress (e.g., nausea, anorexia), fatigue, weakness, dysphagia, increased bronchial secretion and abnormal liver tests.¹ Furthermore, isoniazid should be taken with pyridoxine to help prevent damage to peripheral nerves.⁴

Cilazapril (Inhibace7) is used to treat hypertension and CHF. It is *not* used for tremor in MS. This is an error in the module. Thank you for bringing it to our attention. —LC, CT, JF, LM

1. Koch M, Mostert J, Heersema D, De Keyser J. Tremor in multiple sclerosis. *J Neurol* 2007;254:133-145.
2. Bozek CB, Kastrukoff LF, Wright JM, Perry TL, Larsen TA. A controlled trial of isoniazid therapy for action tremor in multiple sclerosis. *J Neurol* 1987; 234:36–39.
3. Hallett M, Lindsey JW, Adelstein BD, Riley PO. Controlled trial of isoniazid therapy for severe postural cerebellar tremor in multiple sclerosis. *Neurology* 1985; 35:1374–1377.
4. Drug treatments to help manage tremor. Multiple Sclerosis Society UK. 2008. http://www.mssociety.org.uk/about_ms/symptoms/tremor/tremor4.html



Did you see...

...Colorectal Cancer Screening

Since releasing our module on Colorectal Cancer Screening [May 2008], the US Preventive Services Task Force has provided new screening recommendations.¹ Key changes include:

- There are now *three* Grade A recommendations for screening adults age 50-75:
 - (1) FOBT high sensitivity test annually
 - (2) Colonoscopy every 10 years alone (*NEW*)
 - (3) Sigmoidoscopy every five years together with annual FOBT (*NEW*)
- Since there is at least moderate certainty that the net benefit is small, there is a recommendation *against* routinely screening adults age 76–85 (even though there may be considerations that support screening in an individual patient). However, screening is *not* recommended for any adults older than 85 (Grade D).

In light of the risks and benefits of these "A" tests, clinicians are encouraged to discuss all options with patients and together decide which is most appropriate. —JW, LC, KM

1. US Preventive Services Task Force. Agency for Healthcare Research and Quality. Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation. *Ann Intern Med* 2008; 149(9). Full report is available at www.ahrq.gov/clinic/uspstf/uspstfcol.htm

Dyslipidemia (August 2007): Controversies about when to treat or not treat elevated lipids

New guidelines from the British National Institute of Clinical Effectiveness (NICE)¹ recommend an approach to treatment decisions that focuses on a patient's baseline risk for cardiovascular disease – similar to that recommended in the Dyslipidemia module based on the 2006 Canadian guidelines. "This approach makes sense, given that most people would not qualify for the studies that have been conducted on cholesterol-lowering medication."² Consistent with the Canadian guidelines, NICE recommends that the 10-year risk for patients without pre-existing heart disease be determined using a calculator based on the Framingham data.^{1,3} However, NICE then recommends explicitly increasing the risk if the patient has any first-degree relatives with premature heart disease.

However, there are some major differences in primary prevention. NICE recommends that *only* those with a final risk level of at least 20% be treated – not those with an intermediate risk of 10-19%. Patients who meet the criteria would be treated with simvastatin 40 mg/day (although there is also strong evidence for low dose atorvastatin at 10 mg once daily⁴). Surprisingly, the guidelines advocate a “hands-off” approach and do *not* recommend checking response to therapy *or* increasing the dose.^{1,2} These recommendations are applied to both men and women, even though cholesterol-lowering has not been shown to decrease mortality in women.”^{5,6} The UK and Canadian guidelines make similar recommendations for secondary prevention. — LC, JF, LT, JW

1. Cooper A, O'Flynn N. Risk assessment and lipid modification for primary and secondary prevention of cardiovascular disease: summary of NICE guidance. *BMJ* 2008;336:1246-1248.
2. Cooper A, O'Flynn N. Risk assessment and lipid modification for primary and secondary prevention of cardiovascular disease: summary of NICE guidance. *BMJ* 2008;336:1246-1248. In: *InfoPOEMS: The Clinical Awareness System*. www.InfoPOEMS.com. Accessed October 2008.
3. Cappuccio FP. Commentary: Controversies in NICE guidance on lipid modification for the prevention of cardiovascular disease. *BMJ* 2008;336:1248-1249.
4. Sever PS, Dahlöf B, Poulter NR, Wedel H, Beevers G, Caulfield M, et al. Prevention of coronary and stroke events with atorvastatin in hypertensive patients who have average or lower-than-average cholesterol concentrations, in the Anglo-Scandinavian Cardiac Outcomes Trial-Lipid Lowering Arm (ASCOT-LLA): a multicentre randomized controlled trial. *Lancet* 2003;361:1149-58.
5. Walsh JM, Pignone M. Drug treatment of hyperlipidemia in women. *JAMA* 2004; 291(18):2243-52.
6. Abramson J, Wright JM. Are lipid-lowering guidelines evidence-based? *Lancet* 2007; 369(9557):168-9.

RESEARCH UPDATE contact Stefanie Roder at 905.525.9140 ext. 22223 roders@mcmaster.ca

THANK YOU to all our PBSG members for participating in our Practice Reflection Tool Development Study.



This study was part of a two-year research project funded by the Society for Academic Continuing Medical Education (SACME) under the guidance of Dr. Heather Armson, the principal investigator. Individual study participants completed questionnaires and participated in individual interviews to help refine a newly developed personal practice reflection tool.

The research team at the Foundation for Medical Practice Education is now into the second year of the study (September 2008 - August 2009), which will use this personal practice reflection tool to assess how the nature of the learning environment impacts on practice reflection and the type of commitment-to-change statements made. Three different learning environments will be examined: one-time small group (PBSG Ad Hoc workshops); on-going small group (PBSG) and independent self-learning (PBIL).

Presently, we are still looking for more study participants. If you are interested and like to learn more about this research project, please contact the research coordinator, Stefanie Roder, at 1.800.661.3249.

FOUNDATION NEWS AND NOTICES

Family Medicine Forum 2008 – We will be at booth #119 – right across from the Canadian Armed Forces. Stop by and introduce yourself to the team. **Ad Hoc workshops November 27th:** Postmenopausal Woman’s Health; Endometriosis & Menorrhagia.

First Module Mailing with New Database – Please review your Group Summary carefully and contact Meghan Graham-Martin if there are any discrepancies at 905-525-9140 ext 22572 or 1-800-661-3249, option 0.

FACILITATOR TRAINING WORKSHOPS contact Heather Haywood 800.661.3249 haywood@mcmaster.ca

Spring 2009 Tentative Dates

Saturday, April 18 – Hamilton ▪ Saturday, April 25 – Vancouver ▪ Saturday, April 25 - Eastern (Ottawa/Montreal/Halifax)

UPCOMING MODULES Do you have a module topic suggestion? Send to: fmpe@mcmaster.ca

- Cancer Prevention: The Role of Nutrition ▪ COPD ▪ Fitness to Drive ▪ Pneumonia ▪ Sinusitis

Visit our Website at www.fmpe.org or call (800) 661-3249