

November 2007



Thanks to an enthusiastic, loyal, and committed membership, The Foundation for Medical Practice Education is thriving!

The faculty and staff wish all our members a wonderful holiday season and all the best in 2008.

Editor's Corner

Q: Is there a way that we can ask questions of the module authors?

A: This is actually the aim of this feature-- to provide responses to questions raised by members. We receive many good questions through log sheets, email, and other media. Your questions indicate when some items in a module are unclear or controversial, as well as when additional information is needed. Although we do not have the resources to address each question individually, as much as possible, we try to answer recurrent questions in this section of the Newsletter.

RHEUMATOID ARTHRITIS

Q: Can DMARDs be tapered or discontinued if the patient's rheumatoid arthritis (RA) is in remission? This issue was not covered in the module.

A: The ultimate goal of treating RA is to induce a complete remission. "Complete remission is defined as the absence of the following: 1) symptoms of active inflammatory joint pain (in contrast to mechanical joint pain), 2) morning stiffness, 3) fatigue, 4) synovitis on joint examination, 5) progression of radiographic damage on sequential radiographs, and 6) elevation of the erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) levels."¹

While DMARDs do produce clinical improvement and reduce radiographic progression of RA, complete remission is rare for the majority of patients. For them, the need to continue DMARDs at maintenance dosages will be lifelong.^{1,2,3} Discontinuation may cause a relapse of the disease.⁴

1. American College of Rheumatology Subcommittee on Rheumatoid Arthritis Guidelines. Guidelines for the management of rheumatoid arthritis: 2002 Update. *Arthritis Rheum* 2002; 46(2):328-346.
2. Lacaille D. Rheumatology: 8. Advanced therapy. *CMAJ* 2000; 163(6):721-728.
3. Haraoui B. Canadian Rheumatology Association Position on the Uses of Biologic Agents for the Treatment of Rheumatoid Arthritis. 2001. Canadian Rheumatology Association.
4. Gotzche PC, Hansen M, Stoltenberg M, Svendsen A, Beier J, Faarvang KL, et al. Randomized placebo controlled trial of withdrawal of slow-acting antirheumatic drugs and of observer bias in rheumatoid arthritis. *Scan J Rheumatol* 1996;25(4):194-9.

DID YOU SEE...

Polyethylene Glycol (PEG) reported Safe and Effective for up to 6 Months in Chronic Constipation

After the release of our Constipation module, many PBSG members had comments/questions about PEG, particularly for longer-term use in patients with chronic constipation. The publication of a recent study may shed further light on this issue. A six-month RCT1 (n=304) randomized patients aged 18 to 75 to receive a single daily dose of 17 g PEG 3350 or placebo. “The primary endpoint was no use of rescue laxative, at least 3 satisfactory stools per week, and no more than one of the following: straining, lumpy or hard stools, or a sensation of incomplete evacuation.” This endpoint was achieved by 52% of participants in the PEG group and 11% in the placebo group (number needed to treat = 2.5).

When considering these data, keep in mind that this manufacturer-sponsored study had a high-drop rate—only 170 patients completed the trial. However, withdrawals from the study were proportionately equivalent for each “reason category”, except for lack of efficacy. More than twice as many subjects in the placebo group withdrew for lack of efficacy compared with subjects receiving PEG. While lack of efficacy was the more common reason for drop-out in the placebo group, gastrointestinal complaints (e.g., abdominal distension, diarrhea, flatulence and nausea) were more common the PEG group (PEG 39.7%, placebo 25%, P = 0.015). Most of these GI side-effects were rated as “mild” or “moderate”. Of the 2 patients with “severe” diarrhea, one case resolved spontaneously, while the other required discontinuation of the PEG. Overall, twelve serious adverse events were reported (6 PEG, 6 placebo); none were considered to be related to PEG.

The bottom line? PEG appears to be safe for up to 6 months in otherwise healthy adult patients with chronic constipation. Although nearly half the patients will benefit, approximately 1 in 7 will experience gastrointestinal symptoms related to laxative use.^{1,2}

1. Di Palma JA, Cleveland MV, McGowan J, Herrera JL. A randomized, multicenter placebo-controlled trial of polyethylene glycol laxative for chronic treatment of chronic constipation. *Am J Gastroenterology* 2007;102:1436-1441.
2. InfoPOEMS: The Clinical Awareness System. www.InfoPOEMS.com. Accessed September 6, 2007.

Errata

Dyslipidemia (August 2007)

The acknowledgement of pilot test groups for the module on Dyslipidemia was inadvertently omitted. It should read:

The Foundation’s module team would like to acknowledge, with thanks, the PBSG groups facilitated by Dr. Cyprian Enweani (Saskatoon, SK) and Dr. John Hofhuis (Port Stanley, ON), who pilot-tested this educational module.

Inflammatory Bowel Disease, Appendix 1 (August 2007)

The dose of Azathioprine is 1-3 mg PER KG per day. The “per Kg” was inadvertently omitted in the module.

Facilitator Training Workshops

Spring 2008

Saturday, April 5 Hamilton
Saturday, April 19 Vancouver
Saturday, April 19 Montreal

Fall 2008

Saturday, October 4 Hamilton
Saturday, October 18 Calgary
Saturday, October 18 Montreal

Contact Heather Haywood
Member Services and Facilitator Training
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