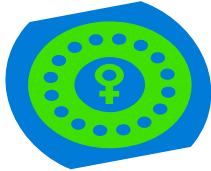




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Oral contraceptives confer long-term protection against ovarian cancer.

It is known that oral contraceptive (OC) use can reduce the risk of ovarian cancer. However, because ovarian cancer is not common in young women and its incidence increases with age, the public-health benefit will depend on how long the reduced risk persists in the decades after OC use discontinues. A recent paper evaluated the duration of protection of OCs against ovarian cancer (*Lancet 2008; 371: 303-14*). The paper evaluated 45 epidemiological studies (n=13 prospective) published up to 2006, involving 23,257 women with ovarian cancer (=cases) and 87,303 without ovarian cancer who had not undergone bilateral oophorectomy (=controls). Information was gathered from each study on usage of OCs and potential confounding factors such as socio-demographic factors, reproductive and menstrual history, family history of breast and/or ovarian cancer, use of HRT, and consumption of alcohol and tobacco. **Results showed an overall reduction of 27% in the relative risk (RR) of ovarian cancer in ever users of OCs compared with never users, which was highly significant.** The reduction begins to show statistical significance after >1 year's use, and the longer women had used OCs, the lower their risk of ovarian cancer; the overall RR decreased by 20% for each 5 years of use. This estimate was not altered (<1% effect) by the above potential confounding factors. As might be expected the RR of ovarian cancer was lower for those women who had more recently used OCs: **the results showed a 29% reduction in relative risk of ovarian cancer for those who had ceased OC use <10 years previously, 19% reduction where OC use had ceased 10-19 years previously and 15% reduction where OC use ceased 20-29 years previously.** The authors point out that these results show a significant and persistent reduced risk of ovarian cancer many decades after discontinuation of OCs. Although the oestrogen content of OCs has changed from high dose (100mcg) in the 1960s to low-dose in the 1980s (<30mcg) the results showed no apparent variation in the risk of ovarian cancer between women from the 1960s-1980s, suggesting no appreciable differential effect of preparations typically used over the decades. The report concludes that the increasing use of OCs in all countries will result in a potential annual reduction of 30,000 ovarian cancers worldwide in the next few decades.



Hear ye, Hear ye, the NMIC needs you!

You will notice that this month's mailing includes a survey on the NMIC publications, which we are sending to all GPs on our mailing list. **We are asking for your support for this survey!** It will give us useful information on how our publications are used in order to improve them for our readers in the future. It should only take a few minutes to complete and an envelope is provided for its safe return to the NMIC. We will publish our findings once all of the data are available and analysed. You have until the **30th May** to complete and return the questionnaire to our medical advisor MaryJo MacAvin, so please help us to help you! [Editor's note: GPs who only receive our publications electronically should email us for a copy of the survey].



People assume expensive drugs work better.

A recent study evaluated the influence of drug price on the efficacy of medical therapies (*JAMA 2008; 9: 1016-7*). A total of 82 healthy paid volunteers were recruited into an established pain study (using electrical shocks administered to the wrist area). Subjects were told that they would receive an FDA-approved opioid preparation, although in reality they were given a placebo. Subjects were randomised into 2 groups: those that were told the drug was a standard price and those that were told the drug had been discounted (no reason given for the discount). Results showed a significantly greater reduction in pain (85%) in the standard price group compared with the discount price group (61%). Similar results were noted when evaluating results from the most painful shocks for each participant (80% vs. 56% reduction). The authors note that this difference in placebo response to commercial features may explain why high-cost medical therapies such as COX-2 inhibitors were more popular with the general public compared with alternative NSAIDs. They recommend that clinicians should be aware of this potential problem and de-emphasise potentially deleterious commercial factors such as the lower cost of generic substitution when prescribing for their patients.



Contemporary management of haemorrhoids. Haemorrhoids are common in all age groups, with reported prevalence rates of 5-30% in primary care studies. A recent paper (*BMJ 2008; 336: 380-3*) reviewed current management options. **Cause:** the anal canal consists of 3 fibrovascular cushions, fed directly by arteriovenous communications, and supported within the anal canal by a connective tissue framework, which help to provide a watertight seal to the anus. Degenerative effects (e.g. ageing), repeated passage of hard stool and straining produce a shearing force on the cushions leading to their descent

and prolapse. These prolapsed cushions have impaired venous return resulting in engorgement (haemorrhoids). The **commonest symptom** is painless fresh rectal bleeding; patients may also experience pruritus, swelling, prolapse, discharge or soiling. Severe pain occurs only when the haemorrhoid is thrombosed or strangulated. **Classification** is important as treatment depends on degree of prolapse as well as severity of symptoms: 1st degree is bleeding but no prolapse, 2nd degree is spontaneously reducing prolapse, 3rd degree is manually reducible prolapse, and 4th degree is permanently prolapsed haemorrhoids.

Management: Fibre supplements have been shown to moderately improve overall symptoms and bleeding and should be initiated at an early stage. Improving anal hygiene, relieving constipation and avoiding straining may be helpful, although the evidence base is lacking. **OTC medications** containing local anaesthetics, astringents, antiseptics or corticosteroids may be helpful but **long-term use should be discouraged**, particularly steroid-containing creams which can permanently damage the perianal skin. **Rubber band ligation** is the best outpatient treatment for 1st-3rd degree haemorrhoids: up to 80% of patients are satisfied with the short-term outcome. Common complications include pain and haemorrhage (up to 5-10 days post-procedure). Sclerotherapy (5% oily phenol) has a high failure rate. **Surgery** is reserved for large symptomatic haemorrhoids failing other treatments. Newer techniques such as Doppler guided artery ligation are less severe than classical haemorrhoidectomy. **Early specialist referral** should be considered in haemorrhoid patients with lower GI symptoms (altered bowel habit, tenesmus or pain) and in patients >40years with rectal bleeding alone.



Oh my aching head! Tension-type headache is characterised by a predisposition to attacks of mild-moderate headache with few associated symptoms. A recent review (*BMJ 2008; 336: 88-92*) outlined its identification and management. **Diagnostic criteria** include: at least 10 episodes of bilateral mild-moderate headache (lasting 30 mins-7 days) of a pressing, non-pulsating quality, not aggravated by routine physical activity, without nausea or vomiting, and with ≤ 1 episode of photophobia or phonophobia. Tension-type headache can

be infrequent episodic (<1 day/mth), frequent episodic (>1 and <15 days/mth) or chronic (≥ 15 days/mth). Patients tend to present only when it has become chronic. Diagnosis is based on presence of the above diagnostic criteria with a normal neurological examination (including fundoscopy). **Manual palpation of pericranial muscles** (includes frontal, temporal, masseter, pterygoid, sternocleidomastoid splenius, trapezius) **very often shows tenderness**. **Differential diagnoses** include migraine, neck-related headache and medication overuse headache (latter very likely with use of opioid/combination analgesics for ≥ 10 days/mth). A **headache diary may help** to clarify the diagnosis if in doubt. **Management** involves treatment for the acute episode and preventive treatment to minimise the number of future attacks. Most evidence is available for efficacy of aspirin 500-1000mg in acute episodes but other NSAIDs (e.g. ibuprofen) have also shown efficacy. GI problems have been reported even with intermittent use of these agents. Paracetamol has shown mixed results but is probably inferior to the NSAIDs. Simple analgesic/caffeine combinations are also effective; opioid combinations should not be used routinely for an acute episode as they impair alertness, and are common causes of overuse headache. Low dose amitriptyline (75-150mg - not authorised) has shown the best efficacy in prevention but side effects such as weight gain, dry mouth and sedation may limit use. Dosage may be increased slowly and continued for 6 months. Biofeedback, acupuncture and manual therapies have been successful at an individual level, but the evidence base is poor.