



# Clinical Digest

## PREVENTIVE MEDICINE

### When to Screen for Postpolypectomy Polyps

A patient is 55, male, has no family history of colorectal cancer, but just had a colonoscopy that revealed a hyperplastic polyp. How soon should he receive a surveillance colonoscopy?

This, and similar questions about differing colonoscopy results, were answered by 568 primary care physicians through a mail survey conducted by researchers from University Hospitals of Cleveland, Cleveland, OH; Henry Ford Hospital, Detroit, MI; and Central Texas Veterans Health Care System, Temple. The investigators found that these providers may be ordering surveillance colonoscopy more often than necessary.

For instance, 61% reported that they would survey a single 6-mm, hyperplastic polyp in the sigmoid colon in five years or less, and 71% reported that they would survey a single 6-mm, tubular adenoma in the sigmoid colon in three years or less. Most would survey two 6-mm, tubular adenomas in three years or less. And 80% would recommend repeat surveillance in five years or less for a patient who'd had a 12-mm, tubular adenoma three years before but who had a normal result on surveillance colonoscopy.

Current guidelines from the U.S. Multisociety Task Force on Colorectal Cancer recommend surveillance colonoscopy every five to 10 years for patients with average risk (one or two adenomas smaller than 1 cm) and every three years for those with three or more adenomas, regardless of size. The researchers note that those intervals could be lengthened, as some data

show that the risk of colorectal cancer in patients who have had adenomas removed may be no greater than that in the general population.

Understandably, factors such as shifting guidelines, malpractice suits, and the very real possibility of missing a polyp that turns a low risk patient into a high risk patient influence practitioners' decision making. The intense surveillance of low risk polyps, however, compromises the capacity to perform screening colonoscopy and evaluation in symptomatic patients, the researchers warn. They note that the reduction in risk from surveillance alone after polypectomy remains unclear. The prevalence of adenomas is 30% to 50%, but the incidence of cancer is 6%. They add the caveat, however, that the results of their survey are based on physicians' self-reports and may not match actual practice.

Source: *Ann Intern Med.* 2006;145:654-659.

## HEPATOLOGY

### Can Thrombocytopenia Signal Cirrhosis?

Thrombocytopenia is a useful surrogate for cirrhosis when identifying patients at high risk for hepatocellular carcinoma (HCC), according to results from a series of three pilot studies led by researchers from Kaohsiung Chang Gung Memorial Hospital, Kaosiung and Chang Gung University, Taoyuan, both in Taiwan. These investigators determined platelet counts and pathologic hepatic fibrosis scores for 122 patients with chronic hepatitis B virus (HBV) infection and 244 patients with chronic hepatitis C virus (HCV) infection, examined the prevalence of thrombocytopenia among 4,042

patients with proven HCC, and screened 201 patients for HCC risk using platelet counts as a marker.

Among patients with chronic HCV, mean platelet counts dropped in relation to both increased pathologic fibrosis scores and parenchyma scores. This was not the case in patients with HBV, however.

Nevertheless, the researchers calculated a cutoff platelet count of  $150 \times 10^3/\text{mm}^3$  for predicting stage IV fibrosis or ultrasound-confirmed cirrhosis in patients with either HCV or HBV. The sensitivity and specificity of this cutoff value were 68% and 76%, respectively, for pathologic cirrhosis and 76% and 88%, respectively, for ultrasound cirrhosis. The validity was comparable to that of other combinations of serum markers for patients at high risk for HCC.

Source: *Cancer.* 2006;107:2212-2222.

## REHABILITATIVE MEDICINE

### Recovering from Stroke with One Hand Tied Up

Promoting the use of the affected hand can strengthen arm function after stroke—and the results can last for at least a year—according to findings from the Extremity Constraint Induced Therapy Evaluation (EXCITE) trial.

All patients had experienced a stroke within the previous three to nine months, with 106 participating in constraint-induced movement therapy (CIMT) and 116 receiving usual care (ranging from no treatment to formal rehabilitation). During CIMT, patients wore a restraining mitt on the less-affected hand while engaging in functional repetitive tasks (such as writing) and behavioral shaping, or adaptive, tasks with the hemiplegic hand. The

researchers encouraged the patients to wear the mitt for 90% of their waking hours over two weeks.

While the control group showed some improvement at 12 months, the CIMT group showed significantly greater improvements immediately after therapy in quality and speed of paretic arm movements and in the quality and amount of paretic arm use in daily life. Moreover, the CIMT group showed improvement at four-, eight-, and 12-month follow-ups. The advantages for the CIMT group on various performance scales lasted for 12 months.

The EXCITE trial is the first randomized, multicenter trial of CIMT among patients experiencing recent stroke, the researchers say. Their results support findings from other studies that have used CIMT for patients with long-term stroke disabilities.

Source: *JAMA*. 2006;296:2095-2104.

**CRITICAL CARE**

**Finding the Right Angle**

Judging the angle of a critically ill patient's backrest can be a difficult task, say researchers from Federal University of São Paulo, São Paulo City, Brazil. They conducted a study in which they presented 160 participants—97 registered nurses, 48 undergraduate nursing



students, and 15 nursing assistants—with 800 backrests (at angles of 20, 30, 35, and 45 degrees) and asked them to estimate their angles. Only 15% of the angles were estimated accurately, with 62% overestimated and 24% underestimated. There was no correlation between the participants' years of nursing experience and the accuracy of their estimates.

The researchers point out that, among other problems, a backrest that isn't elevated enough can put the patient at risk for pulmonary compromise or pulmonary aspiration. They also note that all the study's participants were fully aware of the clinical importance of backrest angles, particularly in patients with respiratory or neurologic conditions, and that 93% did not consider their own angle estimations to be accurate. The researchers call for a more objective, simple, and readily available method of determining backrest angles.

Source: *Heart Lung*. 2006;35:391-396.

**CARDIOVASCULAR DISEASE**

**Early Intervention for CHD: Don't Miss Out**

Primary care physicians miss a surprising number of opportunities to intervene in cases that later lead to acute myocardial infarction (AMI) and hospitalization. This was the conclusion drawn by researchers from Brigham and Women's Hospital, Harvard Medical School, Harvard Vanguard Medical Associates, and Partners Healthcare System, all in Boston, MA, based on a case-control study in a population of 966 patients admitted to the hospital with AMI who had no known history of coronary heart disease (CHD).

More than one quarter (261) of the patients had visited a primary care practitioner in the preceding month, specifically for chest pain or other

CHD symptoms. Of this group, 155 patients were sent directly to the emergency department, but the remaining 106 became "missed opportunities."

The findings weren't surprising, the researchers say, given the lack of structured evaluation in most cases. Half of the patients who did seek primary care in the month prior to their AMI didn't have an electrocardiogram (ECG) during the visit, and when they did, it wasn't always interpreted before they left the office. The researchers add that primary care clinicians may attempt to manage unstable coronary conditions themselves to avoid sending patients to already crowded emergency departments.

What should these clinicians, who don't have access to cardiac enzyme tests or stress testing equipment, do for patients with CHD symptoms? Turn to tools such as the Framingham Risk Score (FRS), the researchers advise. In this study, the FRS was strongly associated with the occurrence of AMI. The researchers note that the FRS can be calculated readily through electronic medical records, either in real-time or intermittently, and placed on the patient's problem list.

An FRS of 10% or higher may prompt more ECGs or influence the interpretation of borderline abnormalities, the researchers suggest. It might also spur practitioners to prescribe cardioprotective medications or hospital evaluations. Among the high risk patients in this study, prescription rates for beta-blocker and aspirin therapy were low. Of 90 patients who had a "moderately elevated" FRS, only 12% began aspirin treatment and only 8% started taking a beta-blocker. ●

Source: *Arch Intern Med*. 2006;166:2237-2243.

**E-mail us at:**  
**fedprac@qhc.com**