Isotonic saline or hypertonic saline: which is best for sinusitis?

TO THE EDITOR:

We have read with interest Rabago et al's letter to the editor, "Nasal irrigation as adjunctive care for acute sinusitis" (*J Fam Pract* 2004; 53:137). The authors recommended using hypertonic saline nasal irrigation once daily at the onset of sinus symptoms until resolution. But there are 3 important disadvantages for hypertonic saline. Hypertonic saline challenge leads to histamine release and can be used as a simple diagnostic test for allergic rhinitis and may provide a model for nasal hyperreactivity.[1] In the same study, isotonic saline dose not make these symptoms as hypertonic challenge.[1] Otherwise, hypertonic saline nasal irrigation leads to substance P release and glandular secretion by means of stimulation of nociceptive nerves, so that there can be pain in patients.[2] Furthermore, sputum induction by hypertonic saline can cause significant bronchoconstriction in patients with chronic obstructive pulmonary disease, despite pretreatment with an inhaled beta-2-agonist.[3]

Isotonic saline nasal washing has been used effectively in the treatment of sinusitis in children.[4–6] As described in the aforementioned studies, an isotonic saline solution is applied—5 dropperfuls in each nostril—at least 4 times a day until the symptoms subside. Isotonic saline solution nasal washing certainly facilitates nasal drainage and cleans the airway from any postnatal discharge.

Nasal isotonic saline solution—with evidence of beneficial effects in the treatment of acute and chronic sinusitis—is a cheap and convenient way of treating these patients. Overall, we do believe that the placebo-controlled cohort trials comparing the effectivenesses and the adverse effects of the isotonic saline and hypertonic saline use in in sinusitis will determine whether the hypertonic saline or the isotonic saline is superior.

Ahmet Karadag, MD, Hanifi Kurtaran, MD, Oguz Tekin, MD, Cem Uraldi, MD, and Timucin Aydogan, *Fatih University, Faculty of Medicine, Ankara, Turkey. E-mail: kara_dag@hotmail.com*

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Aspirin for persons at higher risk for colorectal neoplasia

TO THE EDITOR:

I read with interest the article by Dr Werner and colleagues ("Which healthy adults should take aspirin?," *J Fam Pract* 2004; 53:146–150). However, the authors did not mention the role of aspirin in prevention of colorectal cancer. In randomized trials low-dose aspirin therapy demonstrated risk reduction on colorectal adenomas (precursors of colorectal cancer). Even 81 mg/d revealed a protective effect.[1] Such a small dose might minimize adverse effects as aspirin-related gastrointestinal bleeding. Therefore, persons at higher risk for

colorectal neoplasia might also benefit from low-dose aspirin therapy.

Martin Ritt, MD,
Medical University Innsbruck, Austria

DRS KELSBERG AND WERNER RESPOND:

Thank you for your letter regarding the role of aspirin in the prevention of colorectal cancer. In our literature search for the question: "Which healthy adults should take aspirin?," we also encountered the article you cited. However, that study and others like it looked at aspirin for secondary prevention in patients with prior colon cancer or adenomas. They showed a 5% to 10% absolute decrease in the number of recurrent adenomas with aspirin.

However, it is not yet clear if this would translate into a reduction in colon cancer morbidity or mortality. We found no literature in support of aspirin use for primary prevention of colon cancer. Since we interpreted the question to mean: "Which adults should take aspirin for primary prevention?" we elected to focus on cardiovascular protection where the evidence for primary prevention is already robust. We will be interested to see if future studies expand the preventive role of aspirin to include colorectal cancer.

Gary Kelsberg, MD, Matt Werner, MD, *Valley Family Medicine, Renton, Wash*

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Diagnosis of melanoma

In discussing their interesting melanoma patient in Photo Rounds, Rodriguez and Khachemoune (*J Fam Pract* 2004; 53:541–544) review the ABCD (asymmetry, border irregularity, color variation, and diameter >6 mm) mnemonic for characteristics of melanoma. Some have proposed adding "E" and "F" to this scheme. The "E" is for both "evolution"—a change in a pre-existing lesion—and for "elevation"—vertical growth of (or a vertical component to) pigmented lesions that are usually flat (like nevi arrested in the junctional stage, as found on extremities). The "F" is for "family history," which is another predictor of likelihood of melanoma and is especially important in individuals with clinically or histologically dysplastic nevi. Another clinical clue that can be added to the "D" is "different," different from the company it keeps. For example, if all of the patient's nevi are a "nice" brown, except one that is much darker, that one should be scrutinized very carefully.

In evaluating a lesion, patient characteristics may also help in clinical decision-making. "D" can also stand for "dysplastic"—if a patient has even 1 clinically dysplastic nevus, that doubles the risk of melanoma.[1] If that isn't enough, one can add "G" for "great numbers," because even great numbers of small nevi double the risk for melanoma.[1]

Additionally, there is no rule that all melanomas must have all of the ABCD criteria. I have had residents tell me a lesion cannot be a melanoma because it is <6 mm. The ABCD(EFG) mnemonic is a tool to assist clinicians, not a set of criteria necessary for diagnosis.

Gary N. Fox, MD, *Mercy Health Partners Family Practice Residency, Toledo, OH*

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