

MedALERT

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INFECTIOUS DISEASES

Whooping cough often milder than imagined

A general practice report from the UK indicates whooping cough is often a comparatively mild condition, many cases being hard to diagnose unless the clinician hears the characteristic paroxysms or whoop. Adults may contract the disease from their children and the course is similar. A serious outcome appears rare. Because the disease is easily missed the need to immunise must be stressed to protect infants who suffer the most from whooping cough.

Bordetella pertussis or *parapertussis* is responsible for whooping cough which can be trivial or at times life-threatening with whooping, apnoea, vomiting, pneumonia and encephalopathy. Most people believe whooping cough is always severe because of adverse publicity.

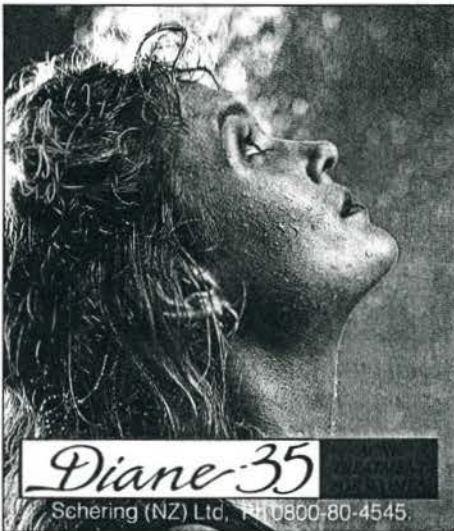
A Nottingham GP studied 500 consecutive cases of whooping cough over a 15-year period to determine the natural course of the condition. Follow-up began in 1977 at the start of a whooping cough outbreak.

In almost all cases the nature of

the cough and duration of symptoms were insufficient for diagnosis.

Within a fortnight of symptoms developing the cough becomes paroxysmal (coughing without pausing for inspiration, turning red or blue in the face) and these occur variably, every 15 min to 12 hours. A sore throat or running nose is not often seen but vomiting, whooping and apnoea are clues to the diagnosis.

After a fortnight of paroxysmal coughing and whooping (sudden inspiration at the end of a paroxysm, followed sometimes by vomiting) the symptoms slowly abate.



Even in the severe phase, paroxysms occurred a mean of 14 times a day (three or four a day, often at night in children) so a doctor may be unlikely to hear them in the surgery.

About half the patients vomited after paroxysms or had a whoop at some time during the condition which lasted a mean of 52 days. The pattern of disease was similar in adults and children but females tended to suffer more than males. Infants and toddlers suffered most of all, sometimes with systemic upset and difficulty feeding. Five children, four aged 5-7 years, developed pneumonia.

Peak incidence was at three years but there was a smaller peak in adults aged a mean of 30 years. Two-thirds

of adults affected were women. Schools caused clustering of cases and adults often seemed to contract the disease from their children.

Just over one-half had not been immunised. Symptoms were less marked in those who had been and isolation of the pathogen was less common, suggesting immunised children are less infectious.

The "overall impression was of a disease much less severe than suggested by textbook descriptions...". The incidence was much higher than the national notification rate, indicating most cases are not recognised or notified.

Patients should realise that while most cases are mild and complications rare, the condition is more serious in infants and therefore "a high immunisation rate is the only practical means of reducing damage and deaths in those too young to be immunised".

Jenkinson D. BMJ 310:299-302, 4 Feb 1995

LIPID ABNORMALITIES

Guides for treating lipid disorders in diabetics

The Australian Diabetes Society in new guidelines advises in-depth lipid testing of all diabetic patients after initial glycaemic stabilisation, followed by initial lifestyle intervention (weight loss/diet and exercise), unless risk is very high in which case drug therapy is required immediately. Lipid abnormalities typically consist of elevated triglycerides and reduced HDL-C levels, so gemfibrozil is appropriate therapy. HMG CoA reductase inhibitors are a good choice if LDL-C is elevated.

Coronary and large vessel atherosclerosis is 2- to 5-fold more common in the diabetic population compared with normals, and risk appears higher in women than men.

Low HDL-C and high triglycerides with or without an elevation of LDL-C is the typical