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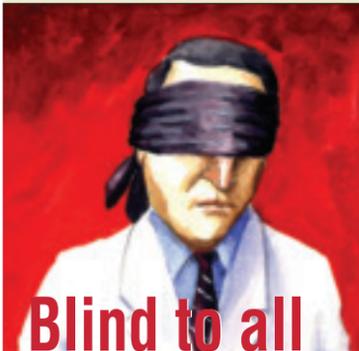
NOVEMBER 14, 2006

A happy side-effect?

Smokers who had been prescribed statins to prevent coronary artery disease may enjoy an unforeseen benefit: a slower deterioration in their lungs. This was one of many studies presented at the annual meeting of the American College of Chest Physicians 23

CME push

The Society of Rural Physicians of Canada is working to bring more—and more relevant—courses to doctors in some of Canada's more remote areas 62

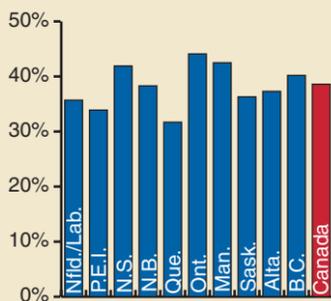


Blind to all the signs

Sometimes a doctor can miss the truth about a patient even when the correct diagnosis is right in front of him 39

Snapshot

Projected government health expenditure as a proportion of total government programs, 2005/06. For more on trends in health spending, see page 8



Source: CIHI



Bristol-Myers Squibb/Charlotte Raymond

Flickers of light in the darkness With almost one-quarter of adults afflicted with AIDS, HIV has devastated the tiny African nation of Lesotho. Here, patients receive care at the Senkatana Centre, which combines medical care with community support programs sponsored by Bristol-Myers Squibb. Dr. Val Rachlis of Toronto visited Lesotho recently and found while there are bright lights of hope in the work of volunteers and the establishment of this centre, he questions whether the developed world is doing enough. See story page 46

Revenge of the stents

New data analyses reaffirm benefits, safety of drug-eluting models

by Andrew Skelly

TORONTO | Drug-eluting coronary stents have received a lot of bad press lately, with reports the two first-generation devices are associated with increased risks of death and myocardial infarction. But new analyses of clinical trial data have failed to back those findings.

The new reports do confirm a small increased risk of thrombosis one to four years after implantation of drug-eluting stents (DES), but

interventional cardiologists say this risk is balanced by lower rates of restenosis—and they point out that longer use of antiplatelet therapy with ASA and clopidogrel (Plavix) may help address the problem.

The latest stent thrombosis controversy heated up earlier this year with presentations at the American College of Cardiology annual meeting in Atlanta and the World Congress of Cardiology in Barcelona suggesting increased mortality and MI risks with the

see Late | page 85

Online MD ratings draw fire from CMPA

Letter reminds Web group about Canadian libel laws

by Alison DeLory

OTTAWA | “The worst of the worst. He butchered me,” is how one anonymous patient rated his or her Canadian physician at www.RateMDs.com.

Other unflattering comments on the Web site, which invites anyone to share a good or bad experience or opinion of a doctor, included: “Are you planning to commit suicide? Go to this doctor and he will kill you.”

The Canadian Medical Protective Association (CMPA) considers these statements defamatory and has successfully pressured the California administrators to delete them from the site. But other comments that remain posted include:

• “Very argumentative and ignores what is being explained to him.”

• “Her level of knowledge appears to be mediocre . . . she didn’t take responsibility for a mistake she clearly made.”

These comments and more are on the Web site next to the names of Canadian doctors.

see Web | page 84

Workers’ comp deal divides B.C. specialists, FPs

by Ann Graham Walker

VANCOUVER | The British Columbia Medical Association board has endorsed it, the BCMA’s Society of Specialist

Physicians and Surgeons (SSPS) has sent out an e-mail asking their members to endorse it—but a proposed new Workers’ Compensation Board agreement is raising howls from

general practitioners who say they weren’t properly consulted. B.C.’s Society of General Practitioners is calling for members to vote against it. GPs make up just less than 50% of BCMA

membership.

The new WCB (now called WorkSafeBC) agreement has been under negotiation for 15 months. There were

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Web site founder says MDs have nothing to fear

from | page 1

In a letter obtained by the *Medical Post*, CMPA executive director Dr. John Gray wrote on Oct. 6 that he is "extremely concerned" about defamatory postings and warns RateMDs.com that such statements are actionable under Canadian law.

"You should be aware that despite the fact that certain users have posted such defamatory statements about our members on your U.S. Web site, they can still be held accountable under Canadian law," wrote Dr. Gray. The CMPA is the principal provider of medical-legal assistance to Canadian physicians.

The site was launched in March 2003 as a place for U.S. patients to find out what others think of a doctor. Canadian doctors were added shortly after the site was launched in the U.S. but it has been slower catching on here and at press time, only 942 of more than 37,000 doctors listed on the site were Canadian. Many Canadian doctors have only one or two patient ratings, whereas some U.S. doctors have responses numbering in the double digits.

"The ratings are probably skewed more to the negative side than they should be. However, there are still a lot of people posting positive reviews," said John Swapcienski, a co-founder of RateMDs.com. By his estimation, about 70% of reviews on the site are positive.

"Further, I think as the site becomes more popular and more 'mainstream,' the outlying, radical opinions are given less weight and moderate viewpoints become more prevalent." Swapcienski said he saw a similar evolution on another Web site he previously launched called RateMyProfessors.com.

Of Dr. Gray's letter and similar feedback he has received, Swapcienski said, "We have received letters of complaint from the CMPA, the CMA and individual Canadian doctors. We definitely are not popular with Canadian doctors but we have a thick skin and we do not scare easily."

In Dr. Gray's letter, the CMPA asked site administrators to remove any Canadian content the CMPA identifies as being defamatory and post a notice to Canadian users about Canadian libel laws informing them that RateMDs.com will disclose the IP (Internet protocol) address or identity of any Canadian user who posts defamatory statements about a Canadian physician. Swapcienski said he doesn't plan to comply.

The site is free to users and site revenue comes from Google advertising.

RateMDs.com does state that it reserves the right to delete comments and entire ratings it feels are inappropriate. It encourages patients to focus only on a doctor's professional ability. Yet Swapcienski admitted occasionally an inappropriate

rating squeaks through.

"We do want comments to be fair but we have little ability to discern which comments are fair and which are not. This is ultimately the responsibility of the individual raters. . . . I do

wrote, "Always makes you feel she knows what is wrong," and scores her five out of five on punctuality, helpfulness and knowledge. Regardless, Dr. Friesen said she does not support the site.

based on only one visit. This is hardly the basis to make a decision about your doctor."

Dr. Friesen is also concerned about comments such as one from a patient who said his or her doctor would rather give

"We have received letters of complaint from the CMPA, the CMA and individual Canadian doctors. We definitely are not popular with Canadian doctors but we have a thick skin and we do not scare easily." — John Swapcienski, a co-founder of RateMDs.com

believe the truth will win out as doctors receive more and more ratings." He said once a doctor has 10 or more ratings the averages become more meaningful.

Site 'offensive'

Dr. Janet Friesen of Surrey, B.C., a *Medical Post* advisory board member, has only one rating thus far. Her patient

"I find it offensive. I hate having my name out in public like that without my permission," she said. Dr. Friesen said she understands patients may want to warn others if they feel a doctor has harmed them but, "like many Web sites, the reader cannot really check the source. All the comments are individual opinion only and may even be

out painkillers than find the cause of the problem, noting it could invite drug-seeking patients into a physician's practice. After 23 years in general practice, she said comments on a Web site are not appreciated but comments made in person are always welcome.

"I can understand then when I have done something that

someone really appreciated and when I have done what the patient thought was wrong and learn something. That is helpful even when it is painful."

Swapcienski said he understands doctors' concerns but said most have nothing to fear.

"As with any profession, there are some bad apples. Hopefully, our site will expose the bad apples and get them to change or drive them out of medicine. Meanwhile, the good doctors are given the recognition they deserve," said Swapcienski.

"Also, I suggest doctors encourage their patients to rate them on RateMDs.com as this is the best protection against what may be a minority of dissatisfied patients."

Dr. Friesen, won't be recommending it to her patients. "As far as I am concerned it lacks all credibility. . . . I hope the CMPA can monitor them somehow."

Dr. Gray of the CMPA declined the *Medical Post's* request for an interview for this story.



Prescribing Information for ACTONEL and ACTONEL PLUS CALCIUM.

Please note that information pertaining to ACTONEL PLUS CALCIUM only is presented in italics. All other information pertains to both products.

[®] ACTONEL [®] Risedronate Sodium (as the hemi-pentahydrate) 5 mg, 30 mg and 35 mg Tablets	[®] ACTONEL [®] PLUS CALCIUM Risedronate Sodium (as the hemi-pentahydrate) 35 mg Tablets and Calcium Carbonate 1250 mg Tablets, USP
THERAPEUTIC CLASSIFICATION	
Bone Metabolism Regulator	Bone Metabolism Regulator and Mineral Supplement

INDICATIONS AND CLINICAL USE

ACTONEL (risedronate sodium hemi-pentahydrate) and the ACTONEL component of ACTONEL PLUS CALCIUM (risedronate sodium hemi-pentahydrate and calcium carbonate) are each indicated for the treatment and prevention of osteoporosis in postmenopausal women.

ACTONEL is also indicated for the treatment and prevention of glucocorticoid-induced osteoporosis in men and women, and Paget's disease of bone. For more information on these indications, please see the ACTONEL Product Monograph.

Treatment of Postmenopausal Osteoporosis: In postmenopausal women with osteoporosis, ACTONEL prevents vertebral and nonvertebral osteoporosis-related fractures and increases bone mineral density (BMD) at all measured skeletal sites of clinical importance for osteoporotic fractures, including spine, hip, and wrist.

Osteoporosis may be confirmed by the presence or history of osteoporotic fracture, or by the finding of low bone mass (for example, at least 2 SD below the premenopausal mean).

Prevention of Postmenopausal Osteoporosis: In postmenopausal patients at risk of developing osteoporosis, ACTONEL preserves or increases BMD at sites of clinical importance for osteoporosis.

ACTONEL may be considered in postmenopausal women who are at risk of developing osteoporosis and for whom the desired clinical outcome is to maintain bone mass and to reduce the risk of fracture.

Factors such as family history of osteoporosis (particularly maternal history), previous fracture, smoking, moderately low BMD, high bone turnover, thin body frame, Caucasian or Asian race, and early menopause are associated with an increased risk of developing osteoporosis and fractures.

The calcium component of ACTONEL PLUS CALCIUM contains calcium carbonate which is a calcium supplement to dietary intake of calcium.

Geriatrics: Of the patients receiving ACTONEL 5 mg daily in postmenopausal osteoporosis studies (see CLINICAL TRIALS), 43% were between 65 and 75 years of age, and 20% were over 75. The corresponding proportions were 26% and 11% in glucocorticoid-induced osteoporosis trials. In the 1-year study comparing daily versus weekly oral dosing regimens of ACTONEL in postmenopausal women, 41% of patients receiving ACTONEL 35 mg Once-a-Week were between 65 and 75 years of age and 23% were over 75.

Based upon the above study populations, no overall differences in efficacy or safety were observed between these patients and younger patients (<65 years).

Pediatrics: Safety and efficacy in children and growing adolescents have not been established.

CONTRAINDICATIONS

- Patients who are hypersensitive to this drug or to any ingredient in the formulation. For a complete listing, see DOSAGE FORMS, COMPOSITION AND PACKAGING
- Hypocalcemia (see WARNINGS AND PRECAUTIONS, General)
- Hypercalcemia from any cause including, but not limited to, hyperparathyroidism, hypercalcemia of malignancy, or sarcoidosis.

WARNINGS AND PRECAUTIONS

General

Before commencing ACTONEL PLUS CALCIUM, patients' calcium requirements should be assessed. It is recommended that patients receive at least 1200-1500 mg per day of calcium from all sources, as well as a daily vitamin D intake of at least 400-800 IU. The calcium carbonate tablet in ACTONEL PLUS CALCIUM provides 500 mg elemental calcium per day and does not contain vitamin D.

Hypocalcemia and other disturbances of bone and mineral metabolism should be effectively treated before starting ACTONEL therapy.

Adequate intake of calcium and vitamin D is important in all patients, especially in patients with Paget's disease in whom bone turnover is significantly elevated (see DRUG INTERACTIONS).

In post-marketing reporting, osteonecrosis of the jaw has been reported in patients treated with bisphosphonates. The majority of reports occurred following dental procedures such as tooth extractions; and have involved cancer patients treated with intravenous bisphosphonates, but some occurred in patients receiving oral treatment for postmenopausal osteoporosis and other diagnoses. Many had signs of local infection, including osteomyelitis. A dental examination with appropriate preventative dentistry should be considered prior to treatment with bisphosphonates in patients with concomitant risk factors (e.g. cancer, immune suppression, head and neck radiotherapy or poor oral hygiene). While on treatment, these patients should avoid invasive dental procedures if possible. For patients requiring dental procedures, there are no data available to suggest whether discontinuation of bisphosphonate treatment prior to the procedure reduces the risk of osteonecrosis of the jaw. Clinical judgment, based on individual risk assessment, should guide the management of patients undergoing dental procedures.

Concomitant use of calcium-containing antacids should be monitored to avoid excessive intake of calcium. Total daily intake of calcium above 1500 mg has not demonstrated additional bone benefits, however daily intake above 2000 mg has been associated with increased risk of adverse effects, including hypercalcemia and kidney stones.

Gastrointestinal

Bisphosphonates may cause upper gastrointestinal disorders such as dysphagia, esophagitis, esophageal ulcer, and gastric ulcer (see ADVERSE REACTIONS). Since some bisphosphonates have been associated with esophagitis and esophageal ulcerations, to facilitate delivery to the stomach and minimize the risk of these events, patients should take ACTONEL while in an upright position (i.e., sitting or standing) and with sufficient plain water (≥ 120 mL). Patients should not lie down for at least 30 minutes after taking the drug. Health professionals should be particularly careful to emphasize the importance of the dosing instructions to patients with a history of esophageal disorders (e.g., inflammation, stricture, ulcer, or disorders of motility).

Patients with achlorhydria may have decreased absorption of calcium that may be attenuated by taking calcium with food. Taking calcium with food enhances absorption. See DOSAGE AND ADMINISTRATION.

Renal

ACTONEL is not recommended for use in patients with severe renal impairment (creatinine clearance <30 mL/min).

Administration of calcium has been associated with a slight increase in the risk of kidney stones. In patients with a history of kidney stones or hypercalcaemia, metabolic assessment to seek treatable causes of these conditions is warranted. If administration of calcium tablets should be needed in these patients, urinary calcium excretion and other appropriate testing should be monitored periodically.

Special Populations

Pregnant Women: ACTONEL is not intended for use during pregnancy. There are no studies of ACTONEL in pregnant women. Calcium crosses the placenta, reaching higher levels in fetal blood than in maternal blood.

Nursing Women: ACTONEL is not intended for use with nursing mothers. It is not known whether risedronate is excreted in human milk. Risedronate was detected in feeding pups exposed to lactating rats for a 24-hour period post-dosing, indicating a small degree of lacteal transfer. Since many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from bisphosphonates, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Calcium is excreted in breast milk.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

Bisphosphonates may cause upper gastrointestinal disorders such as dysphagia, esophagitis, esophageal ulcer and gastric ulcer. It is therefore important to follow the recommended dosing instructions (see DOSAGE AND ADMINISTRATION).

Musculoskeletal pain, rarely severe, has been reported as a common adverse event in patients who received ACTONEL for all indications.

In postmenopausal and glucocorticoid-induced osteoporosis studies with ACTONEL, the most commonly reported adverse reactions were abdominal pain, dyspepsia and nausea.

Most adverse events (AEs) reported in the Phase III postmenopausal osteoporosis, glucocorticoid-induced osteoporosis, and Paget's trials were mild or moderate in severity and did not generally lead to discontinuation of ACTONEL.

Calcium carbonate may cause gastrointestinal adverse effects such as constipation, flatulence, nausea, abdominal pain, and bloating.

Clinical Trial Adverse Drug Reactions

Because clinical trials are conducted under very specific conditions the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and approximate rates of occurrence.

Treatment and Prevention of Postmenopausal Osteoporosis: ACTONEL 5 mg daily has been studied for up to 3 years in over 5000 women enrolled in Phase III clinical trials for treatment or prevention of postmenopausal osteoporosis. Most adverse events reported in these trials were either mild or moderate in severity, and did not lead to discontinuation from the study. The distribution of severe adverse events was similar across treatment groups. In addition, the overall incidence of AEs was found to be comparable amongst ACTONEL and placebo-treated patients.

Table 1 lists adverse events considered possibly or probably drug related, reported in $\geq 1\%$ of ACTONEL 5 mg daily-treated patients, in Phase III postmenopausal osteoporosis trials. Discontinuation of therapy due to serious clinical adverse events occurred in 5.5% of ACTONEL 5 mg daily-treated patients and 6.0% of patients treated with placebo.

Adverse Event	ACTONEL 5 mg N = 1742 (%)	Placebo Control N = 1744 (%)
Body as a Whole		
Abdominal Pain	4.1	3.3
Headache	2.5	2.3
Asthenia	1.0	0.7
Digestive System		
Dyspepsia	5.2	4.8
Nausea	4.8	5.0
Constipation	3.7	3.6
Diarrhea	2.9	2.5
Flatulence	2.1	1.8
Gastritis	1.1	0.9
Skin and Appendages		
Rash	1.4	0.9
Pruritus	1.0	0.5

* Considered to be possibly or probably causally related by clinical study investigators.

Once a Week Dosing: In the 1-year, double-blind, multicentre study comparing ACTONEL 35 mg Once-a-Week to ACTONEL 5 mg daily for the treatment of osteoporosis in postmenopausal women, the overall safety and tolerability profiles of the 2 oral dosing regimens were similar.

Patients with active or a history of upper gastrointestinal disorders at baseline and those taking ASA, non-steroidal anti-inflammatory drugs (NSAIDs) or drugs traditionally used for the treatment of peptic ulcers were not specifically excluded from participating in the ACTONEL Once-a-Week dosing study. The proportion of patients who experienced an upper gastrointestinal adverse event and the pattern of those events were found to be similar between the ACTONEL 35 mg Once-a-Week and ACTONEL 5 mg daily-treated groups.

In the 1-year, double-blind, multicentre study comparing ACTONEL 35 mg Once-a-Week to placebo for the prevention of osteoporosis in postmenopausal women, the overall safety and tolerability profiles of the two groups were comparable with the exception of "arthralgia". Specifically, 13.9% of patients taking ACTONEL 35 mg Once-a-Week experienced arthralgia compared to 7.8% of placebo patients. The overall safety profile observed in this study showed no substantive difference from that observed in the ACTONEL 5 mg daily versus ACTONEL 35 mg Once-a-Week treatment study.

Endoscopic Findings: ACTONEL 5 mg daily clinical studies enrolled over 5700 patients for the treatment and prevention of postmenopausal and glucocorticoid-induced osteoporosis, many with pre-existing gastrointestinal disease and concomitant use of NSAIDs or ASA. Investigators were encouraged to perform endoscopies in any patients with moderate-to-severe gastrointestinal complaints while maintaining the blind. These endoscopies were ultimately performed on equal numbers of patients between the treated and placebo groups (75 ACTONEL; 75 placebo).

Across treatment groups, the percentage of patients with normal esophageal, gastric, and duodenal mucosa on endoscopy was similar (21% ACTONEL; 20% placebo). Positive findings on endoscopy were also generally comparable across treatment groups. There were a higher number of reports of mild duodenitis in the ACTONEL group; however, there were more duodenal ulcers in the placebo group. Clinically important findings (perforations, ulcers, or bleeding) among this symptomatic population were similar between groups (39% ACTONEL; 51% placebo).