Letters to the Editor

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Vitamin C for Preventing Exercise-Induced Asthma

Original Article: Exercise-Induced Bronchoconstriction: Diagnosis and Management

Issue Date: August 15, 2011

Available at: http://www.aafp.org/afp/2011/0815/p427.html

TO THE EDITOR: I would like to point out an easy, low-risk preventive therapy that the article on exercise-induced bronchoconstriction did not mention. Ascorbic acid (vitamin C) taken before exercise can be protective against exercise-induced asthma in some persons.[1,2] The effective dose is 1,500 to 2,000 mg one hour before exercise. This therapy does not replace the need to have an albuterol inhaler available.

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2. Schachter EN, Schlesinger A. The attenuation of exercise-induced bronchospasm by ascorbic acid. *Ann Allergy.* 1982;49(3):146-151.

IN REPLY: Thanks to Dr. Stevenson for mentioning the use of ascorbic acid as a protective agent in the management of exercise-induced asthma. Many different types of therapies have been used, from inhaled heparin to verapamil. I tried to limit this article to therapies with strong evidence-based support.

The studies Dr. Stevenson mentions are intriguing but have several deficiencies. The first deficiency is the number of participants in the study. The Cohen article[1] had only 20 participants, and the Schachter study[2] had only 12 participants. Another problem is that neither study uses exercise challenge testing protocols, which have been shown to be more sensitive and specific in detecting exercise-induced asthma. Lastly, the Cochrane Collaboration reviewed vitamin C supplementation for the treatment of asthma most recently in 2009.[3] Both of these studies were found to have flaws in reporting quality, and the reviewers concluded that the evidence was insufficient to support the use of vitamin C in the management of asthma.

Although many possibly cheaper and simpler treatments may be useful in the management of exercise-induced asthma, physicians should favor evidence-based treatments until these other treatments have stronger evidence to support their use.

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A Walking Stick Can Be a Good Alternative to a Cane

Original Article: Geriatric Assistive Devices

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TO THE EDITOR: The authors of this article, Drs. Bradley and Hernandez, did not mention walking sticks as an option. At 92 years of age, my father did not want to look like an old man, so he began using a walking stick instead of a cane, believing that it would strengthen him by exercising his arm. ▶

For several reasons, I wholeheartedly agree that a walking stick is better than a cane. I see many people who have shoulder problems from leaning on a cane. A walking stick does not put pressure on the shoulder, but rather enables the biceps muscle to hold the body up. In addition, many people using a cane bend forward and take very short steps. The walking stick encourages the patient to stand straighter, have better posture, and walk with a more natural stride (within the limits of the condition requiring the assistive device). I have prescribed walking sticks to several patients who have found them to be more helpful than a cane.

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IN REPLY: We chose to not mention walking sticks in our review article because most studies evaluating the benefits of cane use on gait, balance, joint load, pain, and function were done using standard canes, and did not include walking sticks. However, given the paucity of high-quality randomized controlled trials on assistive device use, anecdotal report is not without value, and Dr. Mendelsohn makes an important point about patient acceptability and adherence.

Our review article focused on assistive device use for patients with gait instability. Walking sticks are probably more beneficial for higher-functioning patients who are interested in the exercise benefit of walking. A small study of mountain walkers found that trekking poles reduced indices of muscle damage, assisted in maintaining muscle function in the days after a mountain trek, and reduced the potential for subsequent injury.[1] Even among hikers, though, up to 95 percent may not use the sticks with correct technique, much like patients using other assistive devices.[2]

One more applicable, but also small, study comparing the effect of a simple cane, a quadripod cane, and a Nordic walking stick on walking capacity, gait parameters, and patient satisfaction in those with hemiparesis found the simple cane to be most efficient and most preferred by patients.[3] If a patient using a cane is having shoulder problems, then his or her technique should be reexamined. The cane height may need to be readjusted, or a walker may be the more appropriate assistive device.

Finally, although other assistive devices are covered by Medicare, walking sticks are not.

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Case Study: Risks Associated with Congenital Varicella Infection

TO THE EDITOR: Chickenpox incidence rates have decreased substantially across the United States since the introduction of the varicella vaccine and subsequent school immunization requirements in many states.[1] This does not mean, however, that the risk of adverse outcomes from varicella infection has disappeared. A recent death from congenital varicella highlights the need for physicians and public health workers to maintain awareness of the threat that varicella poses to pregnant women and their fetuses.

On May 10, 2011, a male infant was born at 34 to 35 weeks' gestation to a 22-year-old mother who reported in April that she had had varicella in the first trimester of the pregnancy. Because of intrauterine growth restriction, the infant's birth weight was 870 g (1 lb, 15 oz). He also had several other conditions consistent with congenital varicella syndrome, including club foot, liver calcifications, dermatome scarring of the face, and microcephaly with ventriculomegaly. Life support was removed, and the infant died on May 13, 2011.

The mother was from Mexico and had not received varicella vaccine, nor had she ▶

had the infection prior to her pregnancy. In April 2011, she reported having chickenpox in January along with a child in her household. A varicella immunoglobulin M antibody assay performed in April was positive. Neither the mother nor her child had sought medical care, and their infections were not reported to the health department by a school or employer.

This case highlights several important considerations. First, the risk of congenital varicella remains, although the incidence and case fatality rates continue to decline.[2] Usually when a vaccine is introduced, the burden of disease shifts from a younger population to an older population. Second, even though use of varicella vaccine is increasing across the country, adults and adolescents may still be at risk because they are typically not targeted by immunization campaigns. Finally, women from tropical areas such as Central or South America may reach adulthood without having had chickenpox, leaving them vulnerable to infection during pregnancy.[3]

Health care professionals need to be aware of the risks of congenital varicella and screen women of childbearing age for immunity to varicella, especially those from Latin America. Screening should begin by asking about the patient's history of varicella infection or vaccination. Those who are unsure or not immune should be vaccinated if they are not pregnant; in those who are pregnant, a titer should be obtained, and the patient should be counseled to avoid contact with persons who have chickenpox or shingles, and to inform her obstetrician immediately if exposure or symptoms occur.[4] Additionally, susceptible pregnant women need to be informed of the risks of congenital varicella, so that they are aware of the importance of reporting such exposures to their physicians for possible intervention (administration of varicella zoster immune globulin, or watchful waiting and administration of acyclovir [Zovirax] if symptoms develop).[3]

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Correction

In the CME Quiz (May 1, 2011, page 1037), Question 7 (page 1038) gave an incorrect description of classic urticarial vasculitis. Classic urticarial vasculitis is characterized by individual wheals that last for more than 24 hours, are painful, and leave residual hyperpigmentation or purpura. The question should have read: "A patient presents with wheals that produce a burning sensation and last more than 24 hours; when resolved they leave residual hyperpigmented areas. Which one of the following is the best next step?" The online version of the quiz has been corrected.

Clarification

In the article, "Treatment of Alzheimer Disease" (June 15, 2011, page 1403), the first clinical recommendation in the Strength of Recommendation Taxonomy (SORT) table (page 1404) was not as complete or balanced as it should have been. The recommendation, "Acetylcholinesterase inhibitors should be considered first-line therapy for patients with mild to moderate Alzheimer disease," should have mentioned the adverse effects associated with this drug class. The revised recommendation should read: "Acetylcholinesterase inhibitors are modestly effective in patients with mild to moderate Alzheimer disease, although limited by their adverse effects." The article has been corrected online. ■