



Statinopathy?

Family physicians may face a myriad of symptoms in patients who are taking several medications for concurrent illnesses and conditions. In these circumstances it can be difficult to admit that the physician may be making the patient sick through the unforeseen effects of prescription drugs. Lipid-lowering “statins” are a problem in this regard, because their adverse drug reactions may be subtle.

In an earlier communication,¹ I described an elderly patient with severe headaches who saw several internists in addition to me, who tried every medication for every sort of headache and who was even admitted to hospital. Yet she wasn't cured until she stopped taking her statin. Five years have passed, and we physicians continue to be fooled by such cases.

In urban medical practice a single patient may receive prescriptions from several specialists, and it is often the job of the family physician to identify possible adverse drug reactions, particularly when a suspicious new symptom develops in the gastrointestinal or central nervous system. Similarly, we continue to misdiagnose headaches, dizziness, asthenia and insomnia in patients taking statins. The dangers here are the initiation of a “prescribing cascade,” as we try to cure an adverse drug reaction through more medication, and the trend to perform investigations such as gastroscopy and CT scanning of the head.

Statins seem invaluable for lipid-related vascular disease, but they must be prescribed with an eye to possible adverse drug reactions. My practice for patients suffering from “polypharmacy” is to stop the statin first. If the symptoms persist, I am happy to resume the prescription at the next visit. Some patients object to this strategy, because they share my

opinion on the necessity of statins and may prefer heartburn to high lipid levels.

David Rapoport, MD
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Reference

1. Rapoport D. Unrecognized adverse drug reactions [letter]. *CMAJ* 1993;149[9]:1233.

Thrombolytics for stroke

I was stimulated by the discussion about thrombolytic agents for coronary artery blockage, “Answering the hard questions about thrombolysis” (letters from Dr. Steve Socransky, *CMAJ* 1998;158[12]:1600; Dr. Michael Schull, *CMAJ* 1998;158[12]:1600-1; Dr. Syed W. Yusuf, *CMAJ* 1998;158[12]:1601-2; and reply from Dr. James Brophy, *CMAJ* 1998;158[12]:1602).

Having had severe left hemiplegia since suffering right middle cerebral thrombosis, I have developed great interest in such treatment. It is not available here in Kingston, Ont., because the university faculty believe the danger of bleeding is too great. So one must live with crippling paralysis with or without a thalamus pain syndrome, depending on ASA and short-term heparin therapy for treatment.

My physician friends from the US do not understand my continued dis-

ability. They seem to have success in treating paralysis by lysing the thrombus.

Are there in fact adverse effects of treating stroke by thrombolysis?

John W. Hazlett, MD
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[Dr. Antoine Hakim responds:]

Dr. Hazlett wonders why he is not receiving thrombolytic treatment to treat his paralysis from stroke. There are several reasons. First, thrombolytic agents for stroke are effective only when administered in the first 3 hours after the stroke occurs. Unfortunately, the effects of Hazlett's stroke are now well established. Hazlett also refers to concern about the danger of bleeding. In a trial of tissue plasminogen activator (t-PA) administered up to 3 hours after stroke¹ the bleeding rate was 10 times greater in patients receiving the drug than in patients receiving placebo. The drug significantly reduced morbidity from stroke, but many physicians remain concerned about the high rate of hemorrhage. Finally, t-PA is not yet approved in Canada for the indication of stroke.

None of these explanations reduces Hazlett's deficit and pain. He is not alone: 50 000 cases of stroke occur in this country every year. His