Title
Use of evidence-based therapies in a community-based sample of older African-Americans and Latinos with diabetes

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Authors
Brown, AF
Goodman, E
Steers, WN
et al.

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reported use of a CAM therapy, 68% reported using some DS and 50% reported
Francisco, CA.

PATIENTS: A DESCRIPTIVE STUDY
health care providers can best advise patients to integrate dietary supplements
worse antiretroviral adherence. More research is needed to determine how
use (OR 2.9; 95% CI 1.4, 6.4). 95% of HIV infected participants reported use of
antiretroviral therapy.

CONCLUSIONS: Despite employing a number of consent modifications, most
obtain fluency in English or Spanish. We employed a modified, interactive
consenting for a randomized trial of advance directives. Participants had to self-
consent information.

RESULTS: Participants had a mean age of 61 years; 53% were female; 26% were
white, 18% were homosexual and 53% reported illicit drug use in the last 5
years. HIV infected individuals were similar to HIV uninfected individuals in age,
educational attainment, and illicit drug use but were more likely to be Black (OR 1.56; 95% CI 1.1, 2.2). CAM use in the 6 months was compared to baseline and
reported use of a CAM therapy, 68% reported using some DS and 50% reported
daily DS use. In bivariate analyses daily DS use was associated with being HIV infected
(OR 0.50; 95% CI 0.31, 0.81), history of illicit drug use and s-TOFHLA score. In
multivariate analyses, controlling for gender and race, HIV infected individuals were almost 3 times more likely to report daily DS use (OR 2.9; 95% CI 1.4, 6.4). 95% of HIV infected participants reported use of
both DS and other prescription medications. We employed a modified, interactive
giving beta blockers was 0.13 (CI 0.02–0.91; p =0.007). Reasons for giving beta
an MI. Relative risk of MI following administration of beta blocker vs. MI without

BACKGROUND: Studies done in the mid-late 1980s and early 1990s suggest that beta blockers induce hypertension and coronary artery spasm when given to active cocaine users. This ultimately led to the current practice of avoiding beta blockers in the setting of cocaine use. However, no human studies have demonstrated an increased risk of myocardial infarction. Therefore, our primary aim was to determine whether beta blockers were safe in patients who are exposed to both beta blockers and cocaine. Furthermore, studies clearly show that beta blockers decrease mortality in patients with MI or systolic dysfunction heart failure. We hypothesized that beta-blockers do not increase the incidence of MI or mortality in patients admitted to an acute care inpatient setting who have recently used cocaine.

METHODS: We conducted a retrospective study analyzing beta blocker use in 365 consecutive patients over a 3 year period at an urban municipal hospital. Inclusion criteria were 1) documentation of cocaine use by urine toxicology and 2) admission to a high acuity bed (telemetry, intensive care and coronary care units). Hospital records were reviewed for documentation of beta blocker use and outcome. Fifteen patients were excluded from the analysis because they had been prescribed beta-blockers as outpatients but had no documented beta-blocker use m-house. One additional patient was excluded from the MI outcome analysis because the temporal relationship between beta blockers and elevated troponin was ambiguous. MI was defined by elevated troponin levels (3 sets taken approximately 6 hours apart with a minimum single value of 0.10) and/or significant ST elevations in 2 contiguous leads by EKG. We secondarily analyzed reasons for use of beta blockers, as well as the temporal relationships between beta blocker administration, toxicologic confirmation of cocaine use and MI at that elevation.

RESULTS: Sixty one patients (17%) were prescribed beta blockers during hospitalization. In the analysis of 350 patients, there were 17 deaths, only 1 of which occurred in a patient who had received beta-blockade (RR for death with beta blockade=0.30, CI 0.04-2.19; p=0.33), 57 patients had MI (48 NSTEMI & 9 STEMI). Only one patient was given beta blockade prior to having an MI. Relative risk of MI following administration of beta blocker vs. MI without prior beta blocker was 0.13 (CI 0.02-0.91; p=0.007). Reasons for giving beta blockers included rule out MI (n=56), on beta blocker at home (n=21), cirrhosis/variceal prophylaxis with propranolol (n=3), and arrhythmia (n=3). Nine patients were started on beta blockers after positive urine toxscreening tool for medical residents would increase the diagnosis and treatment of depression in major depressive disorders in medical training.
USE OF HOMEOPATHIC REMEDIES FOR PAIN: A SYSTEMATIC REVIEW
Background: Although a variety of homeopathic remedies have been used by patients and practitioners to treat pain, questions about their efficacy remain. We performed a systematic review of randomized controlled trials evaluating homeopathic remedies for pain control, and 2 studied muscle soreness after exercise. The 47 studies, diverse clinical contexts and varied remedies investigated, meta-analytic techniques were precluded. Instead, mean differences in visual analog scale (0-100) for pain intensity were calculated for each study. Study quality was assessed by checklist, using methods developed and validated by Jadad.

Methods: We searched MEDLINE database from 1966 to October, 2005 using the following keywords, in English, Spanish, and French: "homeopathic therapy" and "pain management.

Results: We retrieved 12 studies meeting our initial search criteria. One study was subsequently excluded because its primary outcome was "immunomedulatory activity," not pain specifically. Of the 11 studies included, 5 investigated chronic pain conditions (headaches, arthritis, and back pain), 4 involved post-operative pain control, and 2 studied muscle soreness after exercise. The homeopathic remedy tested also varied across studies: arnica (n=4 studies), spiroflor or homeopathic gel (n=2), rhus-tox (n=2), and an individualized menu of homeopathic medicines (n=9). Nine studies compared a homeopathic remedy to placebo and 2 compared homeopathy to active treatments (e.g., anti-inflammatory medication or pain-relieving gel). A total of 1351 participants were included in the 12 eligible studies. Five of the 11 studies received an Jadad score of 5 or greater. The positive studies tested a combination of homeopathic remedy and an unspecified traditional anti-inflammatory treatment. The mean Jadad quality score for the 4 positive studies was 6.2, and 3 of the 11 studies received an Jadad score of 6 or more.

Conclusions: There are relatively few randomized controlled trials investigating homeopathic remedies for pain management. Of the existing studies, there is considerable variation in remedies tested, pain conditions, clinical context, and comparison groups. Furthermore these studies are relatively small (i.e., underpowered to show effect), of short duration, and have methodological shortcomings. Most studies found no significant improvement in pain. Thus, evidence for homeopathic remedies for pain is limited. Further research should focus on conducting larger studies of standardized treatments with more rigorous methodology.

USE OF MASSAGE THERAPY IN LOW BACK PAIN IN AN URBAN COMMUNITY HEALTH CARE CENTER, S.L. Scrupin, C.A. Levine. *Albert Einstein College of Medicine, Bronx, NY. (Tracking ID # 57944)

Background: The high prevalence, public health impact and health care expenditures of chronic low back pain are well known. Massage has been found to be a popular, effective and safe treatment modality for low back pain. Little is known about its use and barriers to use in the general population. This project was to explore the utility of interest in, and potential barriers to the use of massage therapy in our patients with low back pain.

Methods: We assessed a convenience sample of 240 patients at a South Bronx community health care center via a standardized questionnaire interview administered verbally in English. Chi-square analysis was performed on the data with the help of SPSS.

Results: Sixty percent of the subjects were women, 40% were Black, 35% were Hispanic and 20% were mixed race. Age ranged from 18-84 years old with an average age of 26 years old. Seventy-three percent of patients were insured by Medicare and 6% were insured by Medicaid. Thirty-seven percent were enrolled in a managed care plan.

Four percent of the patients reported cutting down on the amount of time, 80% reported accomplishing less, 81% reported having difficulty performing daily activities due to their low back pain. Forty-nine percent reported using massage to treat their LBP. Females had LBP more frequently (p=0.013). Males felt more uncomfortable about receiving massage (p=0.041) and less frequently had money for massage (p=0.038). Hispanics perceived greater efficacy of massage (p=0.012). Other commonly employed treatment modalities for chronic LBP included: Over-the-counter pain medications (86%), prescribed pain medications (58%) and heat (59%). Patients reported receiving massage from family members and friends (84%) and by professionals (16%) and 46% reported it as helpful. Barriers to massage that were most frequently cited were lack of knowledge (56%), not knowing how to find a massage therapist (68%), and financial constraints (77%). Ninety-five percent of respondents with chronic LBP reported interest in receiving massage therapy. Eighteen percent would try it regardless of fee, 36% for a small fee ($1-$25), and 41% only if free.

Conclusions: LBP is a common and significantly disabling problem in our patient population. Massage has been used by many of our patients with LBP with perceived efficacy. The majority of patients with chronic LBP would be interested in utilizing massage therapy if available at our clinic with 54% willing to pay for massage services regardless of the fee or for a small fee. Our results suggest the provision of massage therapy for LBP would be utilized by a significant portion of our patient population with this common medical problem.

USE OF POLYMER-COATED EXTENDED-RELEASE MORPHINE SULFATE IN THE TREATMENT OF CHRONIC, NON-MALIGNANT BACK PAIN. 1,2 S.L. Scrupin, T.R. Ross, B. Nicholson. 2 Casa Colina Centers for Rehabilitation, Upland CA; 2 Non-Surgical Orthopaedic & Spine Center; Marietta, GA; 1 Brigham and Women’s Hospital, Chestnut Hill, MA; 2 Anaheim Valley Hospital & Healthcare Network; Los Angeles, CA.

Background: Ideal treatment of chronic back pain (CBP) is multimodal and multidisciplinary. Use of pharmacologic agents for pain relief may facilitate the effectiveness of interventions such as exercise and rehabilitative therapies.1,2 When other medications have failed or are not acceptable due to side effects, the effectiveness of interventions such as exercise and rehabilitative therapies.1,2 When other medications have failed or are not acceptable due to side effects, the role of opioids in treating appropriate patients with CBP is gaining recognition.1,2 When pain is chronic, long-acting formulations are preferred over short-acting forms to provide continuous analgesia.3 The purpose of this analysis is to determine the efficacy and tolerability of polymer-coated extended-release morphine sulfate (P-ERMS), a long-acting morphine formulation, in patients with CBP.

Methods: Data on 662 patients reporting back pain as a primary indication were included. In the subset of participants who were taking P-ERMS, a long-acting morphine formula-