

What about the role of sulfasalazine?

Although we agree with Klassen and colleagues¹ that their patient's acute interstitial nephritis was most likely caused by pantoprazole, we note that the patient was also on sulfasalazine.

Several case reports in inflammatory bowel disease populations have identified an association with acute interstitial nephritis and sulfasalazine use, as well as with other 5-aminosalicylate (5-ASA) moieties.^{2,3} A mean overall nephrotoxicity rate of 0.3% has been identified in 5-ASA trials in inflammatory bowel disease, comprising 2671 patients over a total of 3070 person-years of follow-up.² Nephrotoxicity in this population usually presented as interstitial nephritis.⁴ The American College of Gastroenterology's *Ulcerative Colitis Practice Guidelines in Adults* recommend serum creatinine measurements prior to and periodically during treatment with a 5-ASA moiety.⁴

Although more case reports identify acute interstitial nephritis with mesalazine than with sulfasalazine, data from observational studies suggest that the nephrotoxicity potential of mesalazine and sulfasalazine is similar.² 5-ASA-induced acute interstitial nephritis is most frequently reported in the first 12 months of use, but delayed presentations several years after drug initiation have been reported.² 5-ASA-induced acute interstitial nephritis apparently is the result of an idiosyncratic rather than a dose-response-related reaction.² 5-ASA withdrawal, especially if done early, results in renal recovery in the majority of patients.²

Although the patient in the case by Klassen and colleagues¹ had presumably been receiving sulfasalazine for longer than pantoprazole, and pantoprazole was discontinued after sulfasalazine, both drugs have been implicated in acute interstitial nephritis. Because this information is a minor confounder, it may downgrade the calculated Naranjo score. Although pantoprazole remains the most likely culprit in this case¹, acute interstitial nephritis may have been caused by a delayed reaction to sulfasalazine. Acute interstitial

nephritis is a serious adverse event where early recognition and discontinuation of culprit drugs, like pantoprazole and sulfasalazine, can improve outcomes.

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Dementia and history of trauma

Regarding the *CMAJ* Salon article, "What my 5-year-old son taught me about medicine,"¹ I commend Dodek's sensitivity to his son's visit with Anni at the nursing home. I wonder however, if there weren't more to their gentle interaction than met the eye. While studying for my master's degree in counselling, I completed two practicums concurrently, one in a trauma therapy certification program and the other as a counselling assistant at a residence for patients with Alzheimer disease or other types of dementia.

One resident with advanced dementia was generally unapproachable, withdrawn and uncommunicative. During the Christmas season, a group of children arrived to sing carols at the facility. She became very agitated and tried, quite violently, to push the children out of the room. The assumption by staff was that, in her dementia and old age, she did not like children. Upon reading the social history of the patient, I discovered that as a young woman she had lived in a war-torn country. One day while walking in her village, she saw a

class of children out with their teacher on a field trip. They began to cross the bridge that she herself had just traversed. Suddenly, there was a huge explosion behind her. When she looked back, the bridge had been bombed; the children and their teacher all died in the event.

This story led me to more and more research of the trauma history of many of the residents and, almost without exception, I came to the conclusion that much of their repetitive, often violent behaviour was the result of previously experienced traumatic events. In their dementia they continued to act out, appearing to attempt to resolve and heal the emotional scars of these earlier experiences. This woman, I believe, was still desperately trying to keep the children safe. To my knowledge, little research has yet to be done on the possibility that dementia, in particular Alzheimer disease, can be the result of long-term dysregulation of nervous system biochemistry in the body and the resulting neurological deficits. Dodek's story, I am certain, reflects the history of his patient Anni. Did Anni see something in Max that no one else could see — perhaps her past as a tender and loving mother who had lost her child many years before? Further research leading to a deeper understanding of the connection between unresolved life trauma and some types of dementia would perhaps lead to more compassionate therapeutic care for patients with dementia.

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Urethral discharge

I would like to congratulate Rebick and colleagues¹ on their article on the treatment of urethral infections. In their elegant work, the authors describe the tests available for specific diagnosis of various causes of urethritis in men and conclude

by analyzing the guidelines on medical treatment, stressing the high risk of relapse or reinfection and consequent recommendations for posttreatment tests.

Recommendations for follow-up cultures or tests of cure are essential in order to show possible recurring infections or re-infection, thus minimizing any late complications related to infection. As emphasized by Rebick and colleagues¹ in case of failure of treatment, the patient should be referred to a specialist in sexually transmitted diseases for proper management of the infection.

To emphasize the need for correct management of urethral reinfections or the recurrence of previously treated urethritis, I would like to stress some points. First, many infections (and reinfections) of the urethra are asymptomatic, making the diagnosis of failure of treatment very difficult.

Second, failure of medical treatment may be due not only to inadequate therapy or resistance to antibiotics,² but also to patient behaviour. Often when patients are instructed to abstain from sexual intercourse for at least 1 week after therapy is initiated and prompt treatment of partners is also recommended, many studies have shown that about 30% of cases are positive at rescreening and, in more than 60% of these, repeat infections occur (originating from re-exposure to an untreated or inadequately treated partner).³

Third, one of the most frequent and dramatic late complications of urethritis is inflammatory stricture of the urethra, which usually starts with meatal stenosis, later progressively involving the anterior and posterior urethra and often requiring long-term management. Optical urethrotomy, as described by Sachse in 1974, is still the initial treatment for the majority of men. Unfortunately, this treatment alone is associated with a significantly high recurrence rate, which may reach 50%.⁴

Management of recurrent stenoses is a complex dilemma for urologists.⁵ Given the expanding number of endoscopic techniques available, the choice of the best surgical option is often difficult, and urethral reconstruction has become an increasingly specialized urologic pro-

cedure. Because of the cost and invasiveness of some treatments (e.g., urethroplasty with buccal mucosa grafts), many urologists have limited experience performing more complicated repairs.

In addition, the very definition of success is hampered by nonstandardized follow-up methods, making understanding the outcome of some of these interventions difficult.⁶

Proper medical management of urethral infection is essential, in view of the possible late complications of untreated urethritis. Urethral discharge must never be underestimated.

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