improvement vs 76/287 patients in control groups; 
(P=.0001).1

Five other studies compared VR with other treatments (including canalith repositioning maneuvers such as the Semont and Epley), with dizziness cure rates as the reported outcome. One of these studies was in patients with BPPV. Here, canalith repositioning maneuvers were better than VR (39/42 cured in the canalith repositioning maneuver group vs 18/29 with VR; odds ratio 0.13; 95% CI, 0.03–0.51; P=.004). Another study reviewed selected patients with BPPV and found the Semont maneuver to be superior to VR alone at 15 days, but at 3 months VR with the Semont maneuver was superior to either intervention alone. The Semont maneuver is performed by moving the patient into a lying position that provokes the vertigo for 4 minutes. The patient is then rotated to the opposite position for an additional 4 minutes, after which the patient rises slowly. The somewhat similar Epley maneuver involves a series of 4 movements of the head and body aimed at alleviating vertigo caused from displaced otoliths. Reported difficulties with these treatments include inability to tolerate the positioning maneuvers and emesis.1

A 6-month RCT of 360 patients with vertigo from Ménieré’s disease compared an intervention using self-help booklets on VR or symptom control to waiting list controls. Symptom control consisted of applied relaxation, controlled breathing, and cognitive-behavioral strategies to reduce the amplification of symptoms by anxiety. The study was not controlled for medication use. Patients were recruited by mail and were randomized to receive the VR booklet, the symptom control booklet, or to be on the waiting list. They were evaluated at 3 and 6 months after receiving the booklets, using the 36-item Vertigo Symptom Scale, short form (VSS-SF).2

At 3 months, 35% of both intervention groups reported symptom improvement, compared with 19.2% of controls (P=.006). At 6 months, 37.5% of the VR group and 39.2% of the symptom control group reported improvement compared with 15.8% of waiting list controls (P=.01 for each intervention vs the wait list; number needed to treat=5). No statistically significant difference was noted between VR and symptom control.2

A prospective cohort study of 21 patients with refractory chronic vertigo from Ménieré’s disease showed that of patients using a Meniett device, 71% had either relief or resolution of symptoms at 1 year, and 63% at 3 years. The Meniett device is placed in the middle ear with a myringotomy tube, sending pulsations to the inner ear. Side effects include otitis media and permanent perforation from placement of the myringotomy tube.3

Medical therapies are frequently tried, although no RCTs support their use for chronic vertigo. Experts recommend antihistamines (meclizine) to limit the nausea associated with vertigo. Anticholinergics (scopolamine) are not thought to be effective after symptoms have begun. Small-dose benzodiazepines, diuretics, and calcium channel blockers have been used, but care must be given for potential adverse side effects. Topiramate has also been used, with the favorable side effect of weight loss.4

What preoperative evaluation is indicated in a patient with left bundle branch block?

Evidence-Based Answer
Patients with left bundle branch block (LBBB) who do not have signs or symptoms of coronary artery disease (CAD) or congestive heart failure (CHF) and who have normal functional capacity do not require extensive preoperative cardiac evaluation. (SOR C, based on expert opinion.)

A case-controlled study followed 17,361 subjects over a 40-year period to assess the incidence and course of LBBB. Although LBBB did not alter all-cause mortality, it was associated with increased mortality from CHF (relative risk [RR] 2.4; 95% confidence interval [CI], 1.31–4.41) and myocardial infarction (RR 2.9; 95%CI, 1.27–6.60).1

A cohort study of 7,073 patients (150 of whom had preexisting LBBB) referred for symptom-limited nuclear exercise testing followed patients for 6.7 years, with the primary outcome of all-cause mortality. After adjusting

for confounders (clinical, exercise, and nuclear scintigraphic variables), LBBB was an independent predictor of mortality (hazard ratio [HR] 1.5; 95% CI, 1.0–2.0).²

One study specifically evaluated bundle branch block as a risk factor in noncardiac, nonemergent surgery. This retrospective cohort study investigated patients with LBBB (n=119) or right bundle branch block (RBBB; n=336) undergoing preoperative evaluation for noncardiac surgery. Mean age was 67 years (range 40–93), 64% had hypertension, 18% CHF, 18% a history of CAD, and 22% angina. No cardiovascular complications were observed in the patients with a bundle branch block intraoperatively. Postoperatively, no patients with a bundle branch block experienced myocardial infarction, pulmonary edema, or ventricular dysrhythmias. One patient with LBBB developed atrial fibrillation postoperatively. Four patients (0.9%) with bundle branch blocks (1 with RBBB, 3 with LBBB) died postoperatively compared with 2 (0.4%) in the control cohort. All 3 of the LBBB deaths were due to sepsis (2 after prolonged postoperative hospitalization) and all had known heart disease. Hence, LBBB may be associated with increased noncardiac postoperative complications; however, a larger cohort study is needed to validate this finding.³

The ACC/AHA 2007 Perioperative Executive Summary considers the presence of a LBBB a “minor clinical predictor.” In the absence of clinically active cardiac conditions, such individuals may proceed to low-risk surgery. In patients undergoing other than low-risk surgery, further workup is not required if their functional capacity is greater than 4 metabolic equivalent tests (METs). Patients with poor (<4 METs) or unknown functional capacity undergoing other than low-risk surgery require a clinical risk factor assessment to determine if further evaluation is warranted.⁴

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What treatments are effective for chronic prostatitis?

Evidence-Based Answer

No treatments for chronic prostatitis/chronic pelvic pain syndrome have been proven effective. Ciprofloxacin, tamsulosin, corticosteroids, and rofecoxib have all failed to show benefit. (SOR B, based on a single study for each agent.)

Chronic prostatitis/chronic pelvic pain syndrome is a common disorder that is defined clinically by inflammation of the prostate and discomfort or pain in the perineal or pelvic region, and lower urinary tract symptoms with or without bacteriuria.

In 2001, a double-blind, double-dummy trial compared the effectiveness of ciprofloxacin, tamsulosin, a combination of both drugs, and placebo in patients with chronic prostatitis/chronic pelvic pain syndrome. This trial evaluated 196 men with a score of at least 15 on the National Institute of Health Chronic Prostatitis Symptom Index (the NIH-CPSI, with a maximum of 43 points) and a mean of 6.2 years of symptoms. They were randomized to 1 of 4 groups: 49 were given ciprofloxacin 500 mg twice daily, 49 were given tamsulosin 0.4 mg once daily, 49 were given combination of both drugs, and 49 were given placebo. The NIH-CPSI was readministered at the end of 6 weeks of treatment. Despite a slight decrease in the NIH-CPSI total score in all treatment groups, no statistically significant outcomes were noted.¹

In 2002, a randomized controlled trial (RCT) evaluated the effectiveness of a short course of oral prednisone therapy for chronic prostatitis/chronic pelvic pain syndrome. The trial enrolled 21 men with the condition for at least 6 months, for whom antibiotic therapy had failed. They were randomized to oral prednisone (20 mg daily for 1 week, 15 mg daily for 1 week, 10 mg daily for 1 week, and 5 mg daily for 1 week) or an equivalent placebo. No difference was noted between the groups in outcomes measured by the McGill Pain Questionnaire, the Hospital Anxiety and Depression Scale, General Health Questionnaire-30, and the NIH-CPSI score. A significant limitation in this study was the small number of patients and failure to use intent-to-treat analysis.²

A 2003 multicenter RCT evaluated the effects of rofecoxib therapy for 161 patients with chronic prostatitis: 53 were given rofecoxib 25 mg PO, 49 were


