Challenge of electronic medical records

The June issue has a thoughtful article by Dr Newbery on continuity: the continuity of relationships and of approaches to treatment and abilities. He describes the computer as being unable to ensure continuity, yet it is the computer that will allow the most important continuity in family medicine: that of patient care.

The thread of continuity is more important today than in the past. The appearance of breast screening clinics and cervical testing clinics attests to deficiencies in our recall programs. The care these clinics provide is discontinuous because they care for only one aspect of health. On the other hand, they follow a disease-specific preventive program over time.

With recent advances in postinfarct care or diabetic management, for example, disease-specific continuity of care becomes more critical. Many diseases require years of ongoing management. Many patients have multiple health problems and take multiple treatments that are difficult to follow. It is also difficult to remember when to initiate preventive maneuvers, such as ophthalmic assessment for diabetics or immunization updates. The thread of continuity needs to weave through all these areas.

Family doctors are the only health care professionals who have the breadth of practice to coordinate care for patients. Continuity of care should imply continuity over a disease process, not just episodic care when patients present with a problem.

Flow charts are cumbersome to use for remembering, for example, when menopause started, whether a hysterectomy has been done, what the results of the last Pap smear were and whether another one needs to be done this year, when the last breast examination was performed or mammogram or bone density test was done, whether hormone replacement therapy has been discussed, and whether breast cancer has affected the family. Many other patterns of care require similar diligent documenting of previous events to help direct current care. How many other maneuvers are not used because we are not organized to think of our patients over time?

Dr Newbery is right on two counts. It is time to rethink continuity, and current computer programs are not up to the job of giving us this type of information about our patients. As family doctors we need to take on the challenge of electronic medical records. Computerized electronic records make patient data easily accessible and can display information in a useful manner. Charts become useful documents rather than files of paper sitting in a cabinet. Triggers for timely use of preventive maneuvers can be built into the program. We must think about what data will help us manage our patients and how the data we have can be most useful to us, how we can best follow the threads of our patients’ health.

Continuity of care across patients’ health spectrum can be a reality with computerized records. With the complexity of maneuvers with which we have to deal, this is the future of family medicine.

— J. Graham Swanson, MD, MSC, CCFP, FCFP Burlington, Ont

Reference

Olanzapine: keep an eye on this neuroleptic

As a French-speaking physician, I found some errors in the translation of the original Prescrire article, “Olanzapine. Keep an eye on this neuroleptic.”

The article gave a bad impression of “novel” or “atypical” antipsychotics in general and of olanzapine in particular, which is absolutely unjustified based on a large scientific database.
and on an international consensus of physicians (family physicians, psychiatrists, experts) who prescribe these drugs.

The unknown French authors of this review did not seem to have strong (or any?) clinical experience with olanzapine (not marketed in France at the time of publication). They made false interpretations of or statements about the published data on olanzapine and other novel antipsychotics. For example, their definition of atypical neuroleptics is incorrect based on international literature. The comparative trial by Tran et al demonstrates some superiority of olanzapine over risperidone. One of the most intriguing and important findings of that study was a significantly lower relapse rate for olanzapine at 28 weeks of follow up compared with risperidone.

It is unclear whether any of these agents produce a greater effect than conventional neuroleptics against positive symptoms. Clozapine shows the most convincing efficacy (not yet surpassed) in well-defined refractory schizophrenia. Both clozapine and olanzapine have demonstrated superior efficacy against negative symptoms, but it is unclear whether this is an effect on primary or secondary negative symptoms (related to extrapyramidal symptoms). Path analysis does suggest that olanzapine has a primary effect on negative symptoms and mood symptoms.

Most of these agents have demonstrated superior efficacy against conventional agents on other symptoms of schizophrenia (affective and cognitive) in many double-blind trials; the degree to which the new compounds are clinically superior will require further study. Second-generation compounds are also not all alike; lack of response to one does not preclude response to another.

All the newer agents used in Canada, clozapine; risperidone; olanzapine; quetiapine; and, coming soon, ziprasidone (amisulpiride is not available here), are clearly superior for extrapyramidal symptoms and, with the exception of risperidone, avoid substantial elevation of prolactin levels.

One of the most important aspects of novel antipsychotics is their increased tolerability (especially decreased extrapyramidal symptoms and a probable diminished risk for irreversible tardive dyskinesia). Patients who have fewer side effects are more likely to comply with their medication (noncompliance is an important issue in the treatment, prevention of relapse, and overall cost of schizophrenia).

The warning about active surveillance of patients receiving olanzapine because of putative major side effects is completely incorrect and misleading (the drug could cause transient and mild elevation of hepatic transaminase with no case report of hepatitis or any induced liver disease; very small Q-T prolongation, also seen with other atypical and even more so with typical neuroleptics, with no clinical significance; small and nonsignificant increased blood pressure, yet in clinical practice we see more of a nonsignificant decrease, etc).

My own rating of this misleading article is “not acceptable.” The most damage from this kind of supposed “evidence-based” drug review could be to our psychotic patients who are in great need of the best treatment available.

These “second generation, novel, or atypical” antipsychotics improve the benefit-risk ratio because they have equal or better effect on many symptoms of schizophrenia, a better or a much better tolerability, and a greater likelihood of improving compliance and quality of life for our patients with schizophrenia and related disorders. These medications are now our first-line treatment option.

—Gérard Leblanc, MD, FRCP, Psychiatrist
Québec City, Que

References
5. Working Group for the Canadian Psychiatric Association and the Canadian Alliance for Research on Schizophrenia. Canadian clinical practice guidelines for the...

Response

La revue Prescrire’s editorial staff, whose members are unknown only to those who do not take the trouble to read the list in each issue, have long been persuaded that it is in patients’ best interests for drugs to be strictly assessed and for health professionals to be objectively informed.

A practitioner’s own clinical experience on the efficacy of a given treatment, including neuroleptics, carries a very low level of evidence. For example, many physicians for years prescribed diethylstilbestrol (DES) in early pregnancy, on the basis of their personal experience, despite the unconvincing results of well-conducted trials and with the tragic consequences we all know.

The editorial procedures used by la revue Prescrire are mentioned in each issue of Canadian Family Physician, and a detailed version1 was published in May 1999. Our articles are not “supposed evidence-based.” All our statements are precisely referenced, and all references (complete) are filed and available upon request, allowing readers to check the accuracy of each article.

Regarding olanzapine, the initial clinical assessment file failed to demonstrate that it was more effective than the neuroleptics with which it had been compared. (As for the trial by Tran et al, we stressed the fact that the larger the number of statistical comparisons, the greater the likelihood of finding a “significant” difference purely by chance.)

Based on a sound search for clinical trials comparing olanzapine with placebo or any antipsychotic treatment for those with schizophrenia or schizophreniform psychoses, the authors of a recent Cochrane systematic review have concluded:

The very great losses of follow up make recommendations difficult. In these trials most people given olanzapine stop it within six months to one year. Global impression suggests that 10-15 mg/day of olanzapine is antipsychotic, being better than placebo, but, for those with severe illness, when compared to typicals and atypicals there is little difference for the same outcome. On one sub-scale score, of one mental state rating scale, olanzapine shows superiority over antipsychotics for negative symptoms. This results is difficult to interpret clinically. Such findings need replication in large simple studies and should not form the evidence base of treatment recommendations. Olanzapine may have fewer extrapyramidal effects than chlorpromazine and haloperidol, and, perhaps, than risperidone. Currently not enough data relating to those with treatment-resistant schizophrenia are available to draw definitive conclusions.

Finally, warning readers of the lack of long-term safety follow up and calling for caution, as with all new drugs, is not in our view “completely incorrect.” On the contrary, it is absolutely crucial. Physicians must remain alert to avoid repeating errors such as those committed with DES, isoxicam, terfenadine, vigabatrin, cisapride, and mibefradil, to name a few, all of which were initially heralded as being “more effective and safer.”

—Dr Bruno Toussaint
Chief Editor, la revue Prescrire

References
1. Reid T. Welcome to Prescrire! Evidence-based reviews of drugs [editorial]. Can Fam Physician 1999;45:1133-4 (Eng), 1140-1 (Fr).

Corrections

In the article by Reid et al, “Family physicians and maternity care. Still in the game?” (Can Fam Physician 2000;46:601-11), an error appeared in the opening sentence of the second paragraph of the introduction on page 602. The sentence should read, “In 1983, 36% of family doctors attended births, but by 1995 this figure had dropped to 32%.” The authors apologize for this error.

In the Motherisk Update column in the April issue, “Caffeine during pregnancy?” (Can Fam Physician 2000;46:801-3), a meta-analysis completed by the Motherisk program suggested that the risk for miscarriage and fetal growth retardation increased with daily doses of caffeine above 150 mg/d. This dose was incorrectly reported in the update to be equivalent to six typical cups of coffee a day. Although caffeine content varies among different coffee brands, in the original meta-analysis a cup of coffee was approximately 100 mg in most of the studies included or defined as 74 mg if not reported in the original paper. To calculate daily caffeine doses from beverages, the following mean caffeine equivalents can be used as guidelines:• coffee: 100 mg per 250-mL cup, • decaffeinated coffee: 2 mg per 250-mL cup, • tea: 40 mg per 250-mL cup, and • cola: 47 mg per 375-mL can.

References