Practising preventive medicine

I read with interest the article[1] by Dr Freedman et al on preventive care for the elderly. A few months ago, I wrote a Practice Tip[2] on preventive services, in which I described tables developed to incorporate both Canadian and American recommendations. Dr Freedman and colleagues note that only patients who had periodic health examinations (PHE) performed actually had PHE forms in their charts, making it possible to extract from the chart which measures had been performed. I have found that not having one of my tables on the chart actually prompts me to ask patients to book a PHE. Most preventive services are delivered during the visit specifically booked for this purpose, so I agree with the authors in questioning the task force's recommendation that screening and prevention be implemented opportunistically.

Some opportunistic screening is done during subsequent visits, especially with regard to areas that respond well to counseling, such as smoking; however, I have found that most of the gaps are filled at the next PHE, when the table is reviewed. In my charts, the PHE table is placed in the front of the file, behind the cumulative patient profile, for easy access.

I have been using this method now for almost 2 years. I plan to do a chart audit to quantify the completeness of this approach. During the follow-up PHE, I can spend more time reinforcing some measures, such as diet and exercise, with only brief reminders for other measures, such as folic acid supplementation. Patient satisfaction with this approach seems to be very good, although I cannot quantify this. I welcome feedback on this subject, as I do not know whether my approach is feasible for other family physicians.

— Michelle Greiver, MD, CCFP
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by e-mail

References

1. Freedman A, Pimlott N, Naglie G. Preventive care for the elderly. *Can Fam Physician* 2000;46:350-7.
2. Greiver M. Reminders for preventive services [Practice Tips]. *Can Fam Physician* 1999;45:2613-8.

Drug information incorrect

While reading a review[1] of zolmitriptan in *Canadian Family Physician*, we noticed certain information in the article about our product is incorrect.

It was stated in the abstract that "Zolmitriptan should not be used during migraine attacks by patients using propranolol," and in the section titled "Interactions similar to sumatriptan," the author states that "The zolmitriptan-propranolol combination is contraindicated.…"

These statements are incorrect in that zolmitriptan is *not* contraindicated with propranolol according to the Canadian product monograph. Furthermore, the author states that zolmitriptan and propranolol are contraindicated based on the results of a study by Peck et al.[2] In fact, in this study, the authors concluded that "it is unlikely that the pharmacokinetic changes (for zolmitriptan) will lead to clinically important changes in pharmacological effects" and that "dosage adjustment of zolmitriptan is not required for patients taking propranolol for migraine prophylaxis."

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References

1. Prescrire. Zolmitriptan. New product similar to sumatriptan. *Can Fam Physician* 1999;45:1490-4 (Eng), 1496-1501 (Fr).
2. Peck RW, Seaber EJ, Dixon R, Gillotin CG, Weatherley BC, Layton G, et al. The interaction between propranolol and the novel antimigraine agent zolmitriptan (311C90). *Br J Clin Pharmacol* 1997;44(6):595-9.

Response

Thank you for your letter.

A pharmacokinetic study involving 12 healthy volunteers showed that there is indeed a pharmacokinetic interaction between propranolol and zolmitriptan. This study, of which you sent us a copy, was published in 1997 and corresponds to reference 16 of the Prescrire article published in *Canadian Family Physician*. This pharmacokinetic interaction is mentioned in the summary of product characteristics (SPC) in France, as well as the *Physicians' Desk Reference (PDR)* and the official Canadian documents you sent us.[1,2]

Attitudes differ from country to country on the practical effect of these pharmacokinetic data. In France, the propranolol and zolmitriptan combination was "advised against" in the SPC, as clearly mentioned in the French version of the Prescrire article. Subsequently, it became the subject of a "caution for use": the combination was described as feasible, but only if the zolmitriptan dose was reduced to a maximum of 5 mg per 24 hours.[3] This caution (dose reduction) is not mentioned in the product monograph in Canada or *PDR* in the United States.

We were wrong to translate "advised against" as "contraindicated." And, to take into account the available data and the change in the French authorities' position, we should have stated that the (limited) pharmacokinetic data cautiously suggest that a lower maximal daily dose of zolmitriptan should be prescribed to patients also taking propranolol.

—Dr Bruno Toussaint, Chief Editor
Prescrire International
Paris, France

References

1. Zomig. In: *Dictionnaire Vidal.* OVP Éditions du Vidal. Paris, France: 2000. p. 2279-80.
2. Zomig tablets. In: *Physicians' Desk Reference*. Monyvale, France: Medical Economics Company Inc; 2000. p. 587-90.
3. Prescrire Rédaction. Triptans et propranolol. *Rev Prescr* 1999;19(197):514.

Correction

The article "Preventive care for the elderly" (*Can Fam Physician* 2000;46:350-7) contained an error in the abstract under the heading "Participants" and on page 353 at the end of the first paragraph under "Results." The sentence should read "100 had had PHEs, and a random sample of 36 who had attended the clinic three or more times was chosen from the remaining 81."

Canadian Family Physician apologizes for any inconvenience or embarrassment this error might have caused the authors, Drs Amy Freedman, Nicholas Pimlott, and Gary Naglie.