Clarification required: FOBT or not?

I appreciated the review by Del Giudice et al[1] on the topic of colorectal cancer (CRC) screening referral in the August issue of *Canadian Family Physician*. These guidelines, for the most part, are an excellent overview of a complex process. I write to simply ask for further clarification around the role of fecal occult blood testing (FOBT) as described by the authors.

Del Giudice et al[1] state that positive FOBT results require semiurgent referral, while negative FOBT results do not rule out CRC. Presumably, patients with negative FOBT results would then fall back into the wider pool, in which if their symptoms did not resolve within 4 to 6 weeks, they would also undergo semiurgent referral.

These guidelines seem to propose the following pathways for low-risk, symptomatic patients:

- semiurgent referral for a positive FOBT result (with a test presumably completed over 1 to 2 weeks);
- semiurgent referral for symptoms persisting longer than 4 weeks following a negative FOBT result, or in the absence of an FOBT; and
- no referral required if symptoms resolve in 4 weeks, irrespective of FOBT being done.

The key issue here is that regardless of whether the FOBT is done, a failure of symptoms to resolve in 4 weeks triggers a semiurgent referral and resolution does not. To me, the residual value of ordering an FOBT thus seems to be not to prevent referral, but rather to trigger a semiurgent referral slightly early (perhaps practicably possible 1 to 2 weeks earlier than waiting).

Given the increasing resource pressures on our health care system, there is a growing awareness of the need to avoid unnecessary testing (eg, the Choosing Wisely[2] campaign comes to mind). I wonder if Del Giudice and colleagues could comment on the evidence for improved outcomes and the health system resource burden provided by positive FOBT results triggering semiurgent referrals only slightly earlier, rather than a referral being triggered after 4 weeks of symptoms irrespective of whether the FOBT is ordered; and also explain what evidence led to the guidance that negative FOBT results do not rule out the need for a referral.

Taken together, to my mind, these 2 considerations seem to notably reduce the necessity and value of FOBT as an investigation in CRC screening and diagnosis, which in turn has considerable practice and health system implications.

—Lawrence C. Loh MD MPH CCFP FRCPC
Burnaby, BC

Competing interests
None declared

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Strong force of industry

I thank Dr Spithoff for the timely article "Industry involvement in continuing medical education. Time to say no."[1] The pharmaceutical marketing industry has found it increasingly difficult to access physicians through conventional channels (office detailing, company-sponsored dinners, etc). Instead they have found a new detailing channel: the university academic or researcher.

So now we have the "perfect storm": industry-sponsored research and industry-sponsored researchers who in turn market their research findings (and a company's new products) to physicians who attend continuing medical education events and are anxious to learn the latest from their respected teachers.

Furthermore, these same academic researchers or experts and their colleagues then write clinical practice guidelines supported by their research findings. These guidelines are then disseminated by the guideline agencies through continuing medical education events and lecture tours often with the financial assistance of the pharmaceutical industry. The follow-up can even be a "knowledge transfer" exercise hosted by the College of Family Physicians of Canada and funded by an educational grant from the pharmaceutical industry.

Although disclosures are made and the industry usually has no say in the content, the sponsorship relationship remains a very strong force in "getting the message out." One of the most obvious examples of this marketing scheme has been the massive effort to launch dabigatran in Canada. The result was as follows: the most commonly prescribed new oral anticoagulant in Ontario between 2010 and 2012 was 110 mg of dabigatran[2] despite it being inferior to warfarin in

the prevention of ischemic stroke (110 mg or 150 mg of dabigatran vs warfarin)[3] and having the same rate of serious hemorrhage (including intracranial hemorrhage) as warfarin.[2]

You are absolutely correct, Dr Spithoff. It is time to say no!

—*Murray Trusler* MD MBA FCFP FRRMS
Ottawa, ON

Competing interests
Dr Trusler is Vice President of INR Online Canada Limited, a not-for-profit Canadian company dedicated to the improvement of warfarin management in Canada.

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Pediatric concussion guidelines

I wanted to commend the editors of *Canadian Family Physician* for the focus on pediatric concussion in the recent June issue.[1-4] Persistent concussion affects quality of life across many domains: impaired cognition; impaired memory and attention, affecting school attendance and performance; low mood and decreased social engagement; and reduced peer contact due to removal from sports or recreational activities. A retrospective chart review of a family and sports medicine physician's office[3] and a survey of 2 Toronto community teaching hospitals[4] emphasized the importance of implementing stepwise return-to-learn and return-to-play approaches. Authors from both articles commented that there is a need for clear management plans to facilitate recovery following concussion. Further, Garcia-Rodriguez and Thomas[2] reviewed the current literature to suggest possible validated tools in order to assess child and adolescent concussion. Finally, in a thoughtful commentary, Carson and colleagues emphasized the need to implement best practices.[1] I wholeheartedly agree.

In fact, the Pediatric Emergency Research Canada Concussion Team released the first comprehensive pediatric concussion guidelines on June 25, 2014.[5] These pediatric guidelines were developed by an expert panel including more than 30 members from Canada and the United States and were sponsored by the Ontario Neurotrauma Foundation. The team for this project included representation from the full spectrum of pediatric health disciplines (emergency medicine physicians, family practitioners, neurologists, rehabilitation professionals, etc). The team reviewed more than 4000 academic papers, and over the course of 2 years created the first comprehensive pediatric concussion guidelines for health care professionals, parents and caregivers, and schools or community sports organizations.

These new guidelines[5] provide a "one-stop shop" for busy health care providers by employing evidence-based recommendations to standardize the diagnosis and management of concussion in children aged 5 to 18 years old, from the initial assessment through to the period of recovery (which might last months). Furthermore, it fills a need to standardize the reintegration into school and social activities, both of which are crucial to children and adolescents during formative years.

The guidelines include numerous tools and clear instructions for all levels of users. For the family physician or the emergency department physician, algorithms are provided to guide the decision whether or not to obtain computed tomographic scans, and examples of written discharge handouts for the patients and families are included. For family physicians and