Alan Ogborne has given an accurate synopsis of the identification and treatment of patients with alcohol-related problems and has delineated what is currently thought of as best practice. However, although he recognizes that much identifiable alcohol misuse is not clinically overt he nevertheless advocates the CAGE questionnaire for use in primary care; a more detailed alcohol history is only indicated if such questioning or a physical examination is positive. This approach identifies only the tip of the iceberg: it misses hazardous drinkers before they start to become dependent.

A more proactive method is used in the Department of Emergency Medicine at St. Mary’s Hospital, London, United Kingdom, where the Paddington Alcohol Test (www.cma.ca/cmaj/vol-164/issue-3/0323a.htm) has been developed over the last 7 years. This test is easy (only 3 questions) and takes less than 1 minute to administer. It has been designed to identify misusers at an early stage, at which brief motivational interventions are more effective, and allows treatment to be started earlier. The test is given to all patients presenting with one or more of the “top 10” presenting complaints for which alcohol history is only indicated if such questioning or a physical examination is positive. This approach identifies only the tip of the iceberg: it misses hazardous drinkers before they start to become dependent.

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In the modern context of rationing, evidence-based care and governance, we must move more effectively (that is, earlier) on alcohol misuse.

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References

Treating acute myocardial infarction

In reading the article by Louise Pilote and colleagues on changes in the treatment and outcomes of acute myocardial infarction in Quebec and the related commentary by Arthur Dodek I am reminded of the saying that to a hammer everything looks like a nail.

The authors of both articles speak from the viewpoint of the cardiologist but by the emergency physician, often under conditions far more chaotic and stressful than those in the average coronary care unit. To ignore this and only focus on the portion of care delivered by cardiologists is scientific inaccuracy bordering on arrogance.

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References

Louise Pilote and colleagues have provided a timely stock taking of current treatments and outcomes of acute myocardial infarction. Commentator Arthur Dodek confidently assures the reader that with “contemporary specialized cardiology care the outcome may be as good as it gets.” However, effective alternatives to thrombolytic therapy and revascularization may be needed for patients who have a cardiac crisis far from a fully equipped hospital.

One modern modality perhaps overlooked in both articles is magnesium therapy. In terms of availability, effec-
tiveness, safety and portability, parenteral magnesium would appear to offer the epitome of efficacy in such situations. It also has many features friendly to the heart.¹

Much has been written about the ubiquitous magnesium salts, which until fairly recently were primarily used to treat gastrointestinal problems and pre-eclampsia. Seelig and colleagues outlined a wide range of studies showing positive results in acute myocardial infarction,⁴ one impressive large study being LIMIT-2.² Whereas others demonstrated no benefit,⁵ Frakes and Richardson advocate the use of magnesium in a handful of emergency situations.³ The MAGIC study, involving 10 400 high-risk patients, is currently in progress⁶ and results are expected soon. I would like to see a study performed in which intravenous magnesium is given earlier than the 6-hour limit entered in the MAGIC protocol. Delaying and playing second fiddle may have contributed to the inferior results in some studies.⁸

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References

Daniel Kollek has made a good point in that most patients with acute myocardial infarction are seen initially by emergency physicians. In most cases, emergency physicians now commence thrombolytic therapy. The increased use of thrombolytic agents has been associated with reduced mortality and improved outcomes in the treatment of patients with acute myocardial infarction.¹

However, there are additional factors that may contribute to reductions in inhospital mortality as well to reductions in mortality following hospital discharge: increased use of medications such as β-blockers, angiotensin-converting-enzyme inhibitors and lipid-lowering agents;¹ and increased use of angiography and revascularization procedures.³

Although “primary coronary angioplasty may be the optimal treatment of acute myocardial infarction,”⁶ it is available in only 10% of hospitals and therefore we must rely on prompt treatment with thrombolysis, which is delivered diligently by Kollek and other emergency room physicians.⁷ This pattern of practice has improved patients’ outcomes.

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References