Addressing the challenges of queues

We read with considerable interest the article by Ivo Olivotto and colleagues outlining waiting times from abnormal breast screen to diagnosis for women attending organized screening programs.[1] The authors' findings highlight the excessive waits that endanger patients' health and peace of mind.

However, there are 2 fundamental problems implicit in the authors' discussion. First, their description of diverse diagnostic practices highlights the lack of program control over standard diagnostic strategies. This reality is further evinced by the marked variability in observed waiting times within and between programs. It is difficult, if not impossible, to evaluate the significance of the queue when the very decisions to utilize medical services are themselves questionable. Therefore, a more logical sequence to this study would have been to focus on utilization strategies first and only thereafter turn to an investigation of queues.

Standardization of diagnostic pathways may reduce excessive waits if unnecessary referrals and duplication of tests are eliminated. Yet these measures alone will unlikely suffice in addressing the challenges of the queue for breast cancer evaluation. Hence, the second problem: Olivotto and colleagues focus on organizational reform strategies as solutions to lengthy delays in diagnosis. They cite the experiences in Sweden and the United Kingdom, where a host of organizational strategies and new care routines were invoked and the breast cancer workup was reallocated from the primary caregiver to the specialist. However, these reform strategies ultimately failed, ostensibly because of unchecked increases in utilization and limited funding availability.[2–4] Ontario's experience in managing cardiac queues also illustrates that organizational efforts alone are insufficient to eliminate lengthy delays in service. Centralized triage approaches to cardiac services have not obviated the need for transient funding infusions during times of excessive backlogs — this despite the widespread use of explicit indicators of urgency for patients awaiting bypass surgery.[5]

The problem of excessive waits is a complex one. We must first disentangle and then standardize diagnostic pathways to allow for reasonable comparisons of quality and timeliness of care across jurisdictions. Only then might we suggest solutions with confidence. Ultimately, however, the principles comprising waiting-list management will likely remain the same: system-monitoring processes, explicit prioritization criteria and reasonable supply estimates (although flexibility in capacity should be maintained to meet transient fluctuations in demand).

The authors' study is a step in the right direction, but we are left waiting for a compelling destination to emerge from their work.

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[Three of the authors respond:]

Dalis Rotstein and David Alter have highlighted one problem brought about by a health care planning decision made in Canada in the late 1980s when provincial screening programs were being established in parallel with existing imaging facilities. The organizers of screening programs developed processes to effect recruitment, quality control and evaluation, but for medicopolitical reasons they decided to leave investigation of abnormal screens within the diagnostic sector. The result is that family physicians must continue to work out triage, referral and diagnostic sequences for each woman with a breast screening abnormality. This results in considerable intra- and interprovincial variation in the time to diagnosis, as we demonstrated.[1] This contrasts with a service model in which the screening centre undertakes the diagnostic workup.[2,3]

We disagree that an analysis of this problem needs to start with a description of the sequence of investigations. First, one needs to see if there is a problem (a delay) then one should examine the components of the process, identify opportunities for improvement, implement redesign and finally evaluate whether or not the problem (the delay) has been resolved. The Screening Mammography Program of British Columbia (SMPBC) has taken these steps[4] and demonstrated that process change can reduce delay.[5]

In an SMPBC-sponsored project, 5 BC communities implemented different strategies to improve the diagnostic process after an abnormal breast screen. A simple change had the biggest effect: a screening centre that directly communicated abnormal findings to the diagnostic centre rather than advising the family physician to do the same slashed the median time to diagnosis from 23 to 7 days (p = 0.001) for the 81% of women not requiring a biopsy.[5] Four of the 5 strategies reduced the interval to diagnosis for women requiring biopsy.[5] Facilitated referral from screening to diagnosis has also recently been successfully implemented in other Canadian jurisdictions.

Process change can improve care.

Having the will to implement change is a larger challenge.

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Oral corticosteroids for poison ivy dermatitis

Michael McKee and colleagues have performed a valuable service by documenting the finding that osteonecrosis of the femoral head may result from a short course of a moderate dose of corticosteroids in relatively young men.[1] However, I question their inference in a subsequent letter to the editor that oral corticosteroids are not an appropriate treatment for poison ivy.[2]

Poison ivy dermatitis, although self-limiting, may persist for 2 months or more. Intensely pruritic blisters and dermatitis may cover more than 50% of the body surface and involve areas that cause particular discomfort or embarrassment such as the genitals, face, hands and feet. If untreated, poison ivy dermatitis can result in prolonged absence from work and many sleepless nights. Mild to moderate cases can be treated with local therapy, but the only effective treatment for severe cases is systemic corticosteroids. Use of a potentially toxic therapy such as oral corticosteroids may in fact be more appropriate for a self-limiting condition than for a chronic condition that may recur after the therapy is discontinued.

It would be helpful if the incidence of avascular necrosis resulting from corticosteroid therapy could be more precisely defined. Do the authors have any suggestions why avascular necrosis does not seem to develop in women or men outside of the 20–41-year age range following short-term corticosteroid therapy? Are a significant majority of the authors' patients men who are 20–41 years old? Does alcoholism increase the risk of osteonecrosis with short-term corticosteroid therapy? One of their 3 patients who had poison ivy dermatitis was also an alcoholic and did not develop pain from osteonecrosis until 23 months after his oral corticosteroid therapy.[1]

I continue to prescribe oral corticosteroids for patients with severe progressive poison ivy dermatitis. I continue to warn them of the potential side effects, including the risk of avascular necrosis. Any further information to precisely define the risk would be of great service to my patients.

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[The authors respond:]

As John Goodall has noted, dermatology is not our area of expertise. However, we would make the following points.

First, none of the patients in our series had severe poison ivy dermatitis; they had been prescribed the medication after only a few days or at most a week of symptoms. Second, it is our understanding that there are very few prospective or randomized trials that support the use of corticosteroid medication to treat poison ivy dermatitis. Third, none of our patients remembered being warned about the potential side effect of osteonecrosis with the use of corticosteroid medication. Fourth, our patients told us emphatically that, had they known of such a risk, they would not have taken the medication.

Unfortunately, because our study was essentially a case series,[1] there is no way of knowing the denominator (the size of the pool of patients from which our cases were drawn). In addition, it is our impression that a number of risk factors for osteonecrosis, such as alcoholism, steroid use and trauma, may be additive in terms of causation, but this is extremely difficult to prove statistically.

The preponderance of young people in our series is explained by the fact that our patients were drawn from a referral population of younger people sent specifically for femoral head salvage rather than total hip arthroplasty. However, anecdotally, we are aware of similar cases in older patients. The preponderance of male patients remains unexplained.

Unfortunately, we are unable to provide any specific risk factors for the development of this condition following corticosteroid administration. We agree with Goodall that corticosteroid therapy should be reserved for use in patients with the severe form of poison ivy dermatitis and that patients should be appropriately warned about potential side effects. We look forward to the