Time to rethink EMRs

With use of EMRs in Canada at an all-time high,[1] evidence showing that they improve medical outcomes is very thin at best. We should be practising evidence-based medicine, so why are the provincial and national medical organizations continuing to push EMRs?

EMRs also deteriorate the physician–patient relationship. They are a distraction, and physicians may spend more time looking at their computer screens than at their patients.

EMRs are expensive, time-consuming and complex to set up and maintain. The US, which has the most computerized medical system in the world, also has the most expensive medical system and far worse medical outcomes than most other industrialized nations.[2]

We should learn from our neighbour and focus our resources where they will have the biggest impact. I urge physicians who feel likewise to share these concerns with their local and national politicians and medical associations.

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CMAJ **2015. DOI:10.1503/cmaj.1150033**

Cannabis every day?

In their article on cannabinoid hyperemesis syndrome (CHS),[1] King and Holmes state that the syndrome occurs "in patients who have been using cannabis daily for years," and that "patients with CHS have a history of daily use of natural or synthetic cannabis." This implies that daily cannabis use is a prerequisite for CHS.

According to Simonetto and colleagues,[2] 59% of individuals with CHS report daily use of cannabis, with 25% using it no more than three times weekly, and some using it once a week.

Daily use of cannabis is not required for the development of CHS and, when clinically appropriate, should remain a diagnostic consideration even in relatively infrequent cannabis users.

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CMAJ **2015. DOI:10.1503/cmaj.1150034**

Inguinal hernia

Summarizing advice from Choosing Wisely Canada on minimally symptomatic inguinal hernias in adults, Bohnen re-emphasizes that management may include "watchful waiting for up to two years."[1] Bohnen cites a randomized trial[2] that reported a control group of 364 patients with hernia followed without intervention for two years. These investigators now report the long-term results of their trial,[3] and although the majority of those on long-term follow-up elected to have surgery, the researchers still counsel that watchful waiting for up to 11.5 years is a reasonable and safe strategy. Other Canadian surgeons have also acknowledged that watchful waiting without a time limit is an appropriate strategy for asymptomatic groin hernias.[4]

The author presents estimates of the death rate from elective surgery for inguinal hernia (0.2%, range 0.0%–1.8%) and the death rate from emergency intervention for incarceration/strangulation (4%) but fails to emphasize that the yearly rate of irreducibility associated with a nonoperative approach in such trials is only 0.4%.[5] This means that if 1000 people with a small, minimally symptomatic hernia have elective surgery, 2, or maybe as many as 18, will die from complications. If 1000 such people elect for watchful waiting, 4 will experience an irreducible hernia per year, or 40 after 10 years. Of the 40 experiencing irreducibility, 4% are at risk of dying from emergency surgery, or 1.6 per 1000 people per 10 years. Looks like a distinct advantage for watchful waiting if death from intervention is your main worry.

Also, Bohnen's summary discusses a 55-year-old man: he fails to consider that mortality and complications may increase in seniors.

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The author responds

The argument that minimally symptomatic hernias may be left unoperated upon is well supported by data described by Preshaw[1] and cited in my article,[2] that show irreducibility rates associated with a nonoperative approach and focus on patients with asymptomatic and mildly symptomatic inguinal hernias.

The patient described in my article[2] had a painful hernia that was felt during sporting activities and affected his work.

There is a paucity of information on hernia-related risks in untreated patients with symptomatic inguinal hernias, because symptomatic patients usually have operations. In countries where that is not the case, a substantial burden of disease exists because of morbidities and deaths attributed to hernias.

Most often, surgery is indicated for an otherwise suitable patient who