

## Time to rethink EMRs

With use of EMRs in Canada at an all-time high,<sup>1</sup> 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.<sup>2</sup>

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),<sup>1</sup> 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,<sup>2</sup> 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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## 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.”<sup>1</sup> Bohnen cites a randomized trial<sup>2</sup> 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,<sup>3</sup> 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.<sup>4</sup>

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%.<sup>5</sup> 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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4. Van den Heuvel B, Dwars BJ, Klassen DR, et al. Is surgical repair of an asymptomatic groin hernia appropriate? A review. *Hernia* 2011;15:251-9.
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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<sup>1</sup> and cited in my article,<sup>2</sup> 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<sup>2</sup> 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

understands the risks, benefits and alternatives to surgery — information a surgeon should convey during the decision-making process.

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### New oral anticoagulants

A *CMAJ* letter<sup>1</sup> from a “little cheese” family physician about new oral anticoagulants versus warfarin, and the response<sup>2</sup> from three “big cheese” academic specialists show that readers and authors of guidelines do not always agree.

The Canadian Cardiovascular Society's 2014 update of its *Guidelines for the Management of Atrial Fibrillation*<sup>3</sup> unsystematically strengthened its 2012 recommendation that dabigatran, rivaroxaban, apixaban, and edoxaban (when licensed) are preferred over warfarin for most patients with atrial fibrillation.

The guideline authors note the absence of published randomized trials directly comparing the four new anticoagulants, and assure readers that “it is unlikely that any will be conducted in the near future.”<sup>3</sup> The guideline emphasizes that indirect comparisons between new oral anticoagulants limit our ability to draw inferences on whether any are superior or inferior, and that “any differences in efficacy that might exist among the NOACs [new oral anticoagulants], and even the difference in efficacy between warfarin and each of the NOACs, is very small compared with the reduction of stroke with any OAC [oral anticoagulant] compared with no OAC.”

Can we learn from the example of cancer or combined antiretroviral therapy, where comparative effectiveness trials have led to preferred regimens based upon randomized controlled trials?

Not all clinicians have jumped on the bandwagon. That's likely because of concern that warfarin management

in the control arms of the principal randomized controlled trials was suboptimal according to the US Food and Drug Administration's medical reviewers; we cannot reverse the anticoagulant effect of the new oral anticoagulants or monitor anticoagulant activity; and irregularities in the conduct of the randomized controlled trials may have compromised the apparent evidence.<sup>4-6</sup>

Atrial fibrillation is estimated to affect 350 000 Canadians.<sup>7</sup> Canada could conduct a randomized controlled trial comparing the new oral anticoagulants with warfarin in suitable, comprehensively informed patients with nonvalvular atrial fibrillation and for additional indications for anticoagulation such as venous thromboembolism. With central randomization, the trial could be conducted in the context of usual clinical care, using linked administrative datasets to ascertain the most important clinical outcomes, including death, disability from stroke or intracranial hemorrhage, total serious adverse events and clinically important vascular events. Such a trial could be conducted at a trivial cost when compared to the benefits to health and quality of care. What are we waiting for?

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**Competing interests:** Thomas L. Perry was a pain expert for plaintiff lawyers, US Neurontin lawsuit 2008–2010, an expert consultant for a proposed class action lawsuit against Purdue Pharma (Oxy-Contin) promotion, and a participant in an audit of RE-LY trial (dabigatran) paid by multidistrict litigators (USA). He was also a paid consultant to a multidistrict litigation consortium in the United States on an independent audit of the RE-LY trial (dabigatran). His role was principally to re-adjudicate (blinded) clinical events reported in the trial. No other competing interests were declared.

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### CORRECTION

#### Mobitz II

A practice article that appeared in the Jan. 6, 2015, issue of *CMAJ* contains an error. Box 1, bullet 6 should read as follows:

- Risk factors on electrocardiography, such as:
  - Bifascicular, Mobitz II second-degree, or complete (third-degree) heart block.

#### Reference

1. Soong C, Chen BH, Wong BM. A 62-year-old woman with syncope. *CMAJ* 2015;187:48-9.

*CMAJ* 2015. DOI:10.1503/cmaj.115-0038