Clinical indications on prescriptions

Dear Editor

I would like to share a letter I read in a recent BMJ (4.01.13) by a retired GP with an idea which is so simple it's genius:

"The reasons for prescribing a particular drug may be long forgotten by the patient and sometimes even by the original clinician. A simple solution to this problem is to add the clinical indication to the prescription instructions at the time of issue. This approach is already used by some GPs and is recommended in the General Medical Council's latest guidelines on prescribing." (Nigel J Masters)

Maybe other GPs are already doing this here, but embarrassingly it had never occurred to me, but I am going to implement this from now on.

Dr Joanna Joseph, General Practitioner
Wellington

We think this is a good idea too. More information, including advice about what to do if the patient is concerned about confidentiality, can be found here:
http://clinicalindications.com/index

The reference for the BMJ letter is: Masters NJ. Add clinical indications to prescription instructions to avoid problems of polypharmacy. BMJ. 2013;347:f7496. Available from:
www.bmj.com/content/347/bmj.f7496?tab=citation

As an additional point, some patient management systems have a field for inserting diagnostic indication for the prescription, however, this is not printed out with the prescribing instructions, but is stored within the PMS.

Iron infusions in general practice

Dear Editor

The article "Anaemia on full blood count: investigating beyond the pale" (Best Tests, Sep 2013) mentions iron infusion is appropriate when oral replacement is not tolerated, not effective or not appropriate and it is offered in some general practices. When is oral supplement "inappropriate"?

I wonder if BPAC can give some guidance on when a GP should initiate iron infusion given that it is still generally recommended by specialists in my experience.

Dr Angus Wong
(Online comment)

Iron infusion is usually carried out in secondary care, but increasingly, general practices who have the resources to carry this out (time, skills, resuscitation equipment and anaphylaxis kit), are offering this treatment. Iron infusion may be considered in adults with iron deficiency anaemia if oral treatment is not successful because the patient cannot tolerate the adverse effects (predominantly gastrointestinal) or if the patient is not adherent with treatment, i.e. they are not reliably taking oral medication. It may also be considered in patients where the use of oral iron may be inappropriate such as those with continuing blood loss or patients with gastrointestinal disorders which result in malabsoprtion, e.g. patients with inflammatory bowel disease. Patients with chronic renal failure who are receiving haemodialysis also require intravenous iron administration.

Link between irritable bowel syndrome and restless legs syndrome

Dear Editor

[BPJ 56, Nov, 2013] carries a letter which prompts me to draw attention to a recently noted association between Restless Legs Syndrome and Irritable Bowel Syndrome. About 25% of IBS patients complain of RLS.[1]

As IBS is a relatively common condition, and is now understood to be related to carbohydrate malabsorption and therefore amenable to treatment by dietary manipulation, I would recommend that it is worth asking all RLS patients about IBS

symptoms. They certainly will thank you if offered a chance to mitigate what can be a pair of deeply disturbing conditions.

I also wish to comment on the, I think, unnecessarily strict warning against magnesium supplements given in the accompanying editorial reply. Hypermagnesaemia is a rare condition and typically only seen in patients with more severe grades of chronic kidney disease. The normal adult kidneys are capable of excreting up to about 2000 mg of magnesium daily.[2] Furthermore, only about 40% of dietary magnesium is absorbed, and excess oral intake usually causes diarrhoea rather than systemic toxicity.

Dr Michael Becker, General Practitioner
Raglan

1. Yun C, Lee S, Kim H et al. Association between irritable bowel syndrome and restless legs syndrome in the general population. J Sleep Res 2012;21(5):569-76.
2. Tibor Fulop, MD. Hypermagnesemia. Medscape: http://emedicine.medscape.com/article/246489-overview

In our recent article on IBS (BPJ 58, Feb, 2014) we mentioned that people with IBS may be more likely to have anxiety, depression, fibromyalgia or restless legs. It raises the question that if you improve the patient's IBS symptoms, will you also improve their RLS symptoms (or anxiety, depression, fibromyalgia...), or is this simply showing that the same characteristics that predispose a patient to IBS, predispose them to these conditions?

A question of authorship

Dear Editor
While I value the review articles disseminated via the Best Practice [Journal], and letters to the editor regarding topics discussed, it disturbs me that, almost without exception, there is no authorship ascribed to the published material. I note that relevant medical experts are named, and their contributions acknowledged, but the final document appears as anonymous, in an uncomfortably, almost "Big Brother, 1984" style. This does not encourage an honest and egalitarian discussion of topics covered.

Similarly, if a doctor writes in with a comment or question, his/her identity is always published, but the reply often remains covert (and in a few cases, has been frankly condescending). It is a brave GP that dares to question such a lofty authority!

Please explain why it is that for an article to be published in a peer-reviewed medical journal, the authors must be clearly identified, along with their qualifications, their possible conflicts of interest, and their contact details, yet BPAC does not hold to these internationally recognised and accepted standards. Am I missing something?

Dr Linda Witham, General Practitioner
Hawkes Bay

We do not assign individual authorship to our articles as by the time they are published they have been drafted, reviewed, corrected and edited by the entire publications team – the names of whom can be found on the inside cover of each edition of Best Practice Journal and Best Tests. If an article has been contributed by an external author, this is indicated at the start of the article. Almost all articles that appear in Best Practice Journal or Best Tests are written in-house by our publications team, which is made up of medical writers and clinicians. Our Editor (Rebecca) and medical writers (Mark, Gareth and Noni) have post-graduate health sciences-related qualifications and are members of the Australasian Medical Writers Association. Our clinical team is made up of three experienced General Practitioners (Sharyn, Nigel and Hywel) and Pharmacist (Kirsten). Our Editor-in-Chief (Murray) is also an experienced General Practitioner and CEO of bpac^{nz}. Staff bios for the entire team can be found on our website: **www.bpac.org.nz**

Our topics are decided on by our clinical advisory group which is made up of representatives from primary and secondary care, and healthcare management (the names of whom can also be found inside the front cover of our publications). The role of the group includes indicating key issues to cover within a topic, highlighting appropriate resources and suggesting expert input if required. The article is scoped and drafted by our publications team, then sent out to review with our clinical advisory group and a subject expert. Final revisions are then made by the clinical and editorial teams before articles are compiled into a publication. Final sign-off of each edition is the responsibility of the Editor-in-Chief.

We base our information on New Zealand guidelines, where available. We then look to guidelines from the United Kingdom's National Institute for Health and Care Excellence (NICE), Australian, United States and Canadian guidelines, Cochrane systematic reviews, meta-analyses, and where necessary, primary research. This information is then collated, revised and presented in the context of the New Zealand healthcare system, with guidance from selected experts, depending on the topic. The acknowledgements box at the end of an article lists the experts who have reviewed the article and provided written comment. These experts do not write the articles and are not responsible for the final content.

You correctly point out the requirements for submission to peer reviewed journals. However, Best Practice Journal is not, and does not wish to be, a peer reviewed journal – we aim to provide evidence-based, practical guidance for healthcare professionals working in New Zealand. In relation to any conflict of interest, we do declare our funding sources (PHARMAC and DHB Shared Services) and the names of our five shareholders are also inside the front cover of all publications. We also maintain an active conflict of interest register for all staff.

In regards to correspondence items – correspondents have the option to have their letter published anonymously, which some choose to do. If an expert is consulted for a response to a letter, this is acknowledged, otherwise the answers can be assumed to be from the bpac^{nz} publications team. The purpose of the correspondence section is to reflect on additional questions which have arisen from articles and to promote debate on topical issues; we also publish any feedback on articles or correspondence items online and many people comment directly there. It is certainly not our intention to convey a condescending tone in a response to a correspondence item; we value the wide variety of opinion among the general practice community in New Zealand and appreciate the time people take to write to us and engage with our articles.

The year in review

Dear Editor,
I want to commend BPAC on repeating the main messages from the BPJ editions of 2013. This has very good justification in educational theory. Retention of new information is poor if it is not used within a few days of reading it; repetition is essential, and preferably more than once.

I wonder about finding an appropriate way to repeat the main messages of the previous journal at the start of every BPJ, as well as a collation annually as you have done this time. This will enhance retention and application.

Dr Brett Mann
Medical educator
GP registrar education programme
Christchurch

We thought this was a good idea too, hence the new insert in this latest BPJ! We would love to hear from our readers as to whether this is a useful tool for personal and/or peer review.

We value your feedback. Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz