Getting to the stable door before the horse has bolted

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.[1] However, although he recognizes that much identifiable alcohol misuse is not clinically overt[2] he nevertheless advocates the CAGE questionnaire[3] 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.[4]

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.[5–8] 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 misuse may be considered a root cause. The test is given at the end of the consultation when the patient's initial agenda has been satisfied.

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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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[1] and the related commentary by Arthur Dodek[2] 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 cardiology clinic and the catheterization suite. Although the results that they present are laudable, ascribing them to "increased use of thrombolytic agents and, more importantly, the increased use of angiography and revascularization procedures"[2] ignores the bigger picture.

In my environment, an Ontario tertiary care centre, the vast majority of patients who have a myocardial infarction are treated by emergency physicians and never have primary angiography. This stems from a variety of factors, the most obvious being the lack of availability of angiography outside of business hours. Despite this I would hazard that our statistics on infarct survival mirror the Quebec trend of improvement. Why is this? It is because of an organized emergency medical prehospital system and skilled emergency department staff. If there is an increased use of thrombolytic agents, it must partly, if not completely, be due to the increased thrombolysis in the emergency department.

The time has come to recognize that initial care of patients with myocardial infarction is usually not delivered by 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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Louise Pilote and colleagues have provided a timely stock taking of current treatments and outcomes of acute myocardial infarction.[1] Commentator Arthur Dodek confidently assures the reader that with "contemporary specialized cardiology care the outcome may be as good as it gets."[2] 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-