

MacDonald and colleagues suggest that physicians are reluctant to prescribe opioids because of fears about addiction.¹ Evidence suggests otherwise. Canada and the United States are the biggest consumers of opioids in the world.² Canadian per-capita opioid consumption more than doubled from 1997 to 2006, and consumption of oxycodone climbed rapidly from 2007 to 2010.² In a recent random survey of Ontario family physicians, over 95% of respondents reported prescribing opioids for chronic pain within the last three months; only 1.4% reported not prescribing because of concerns about opioid addiction.³

The authors dismiss concerns about opioids as “frequently exaggerated” and fail to mention the serious and growing public harms. In 2006 in Ontario, 423 people died from an opioid overdose — far fewer deaths were attributed to HIV that year.⁴ In the US, opioid overdose is the second most common cause of death in men aged 35–54 years.² Admissions for prescription opioid addiction treatment have increased substantially in the last 10 years.⁵

This should concern the entire medical community. Physicians’ prescriptions are a major source of the opioids used by addicted patients and overdose victims,⁴ and the risk of overdose is strongly associated with the dose of opioid prescribed.⁶

To resolve the opioid crisis, family physicians and pain specialists must first recognize that, while opioids have an important role in pain management, they can be dangerous when prescribed to the wrong patient or at the wrong dose. A comprehensive educational strategy is needed to give physicians the skills to prescribe opioids safely and to manage the care of patients who are already addicted or taking high doses.

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Centralized electronic health records benefit emergency medicine

Citing British government reports that recommend abandoning their centralized electronic health records (EHRs) project, Paul Christopher Webster continues his assertion that Canada Health Infoway’s vision of a centralized national health database is “not feasible.”^{1,2} However, focusing on the failures of EHRs may lead people to believe that all enterprise digital health solutions are doomed to fail. Although a national top-down-driven EHR system may not work, electronic medical records (EMRs) may be a valuable part of the future of health care in Canada and may become a workable surrogate for an EHR system.

The Government of the Northwest Territories is working on adopting one EMR system for the territories. No matter where a patient goes within the territories, their primary health care data will be accessible to the treating physician or nurse. At the Stanton Territorial Hospital in Yellowknife, Northwest Territories, emergency department physicians use EMRs to view the patient charts of almost half the population of the Northwest Territories. Functioning as a viewing and messaging portal, EMRs allow emergency department physicians to coordinate care with the primary care providers of patients, thus avoiding unnecessary investigations and facilitating continuity of care.

Canada should continue to strive for enterprise health information solutions. A successful system would capture real-time data that follow patients across health services and contain all relevant patient-centric and aggregate data, and are shared across services, thus allowing for rapid communication among providers. In essence, a successful system would be an enterprise EMR.

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Helicobacter pylori and immigrant health

We read with interest the article by Swinkels and colleagues¹ in which a modified Delphi consensus was used to select treatable conditions for immigrants to Canada for future guideline development. We were surprised that *Helicobacter pylori* was not among the infectious diseases identified as high-priority conditions for guideline development. *Helicobacter pylori* causes a chronic infection associated with peptic ulcer disease and is the most significant risk factor for the development of gastric cancer, the second leading cause of cancer death worldwide.² Eradication of *H. pylori* decreases the risk of peptic ulcer disease and, if initiated prior to development of precancerous changes, may prevent gastric cancer.²

Although the prevalence of *H. pylori* is decreasing in Canada, in recent immigrants from places such as Africa, the Middle East, Latin America and Asia the prevalence of infection remains high.³ In a study of African immigrants in Australia, *H. pylori* infection was detected in 60% of participants and was the most common infection. In contrast, Hepatitis B, which was identified as a priority by Swinkels and colleagues, was present in 19% of

individuals.⁴ Many areas such as Asia and South America are high-risk regions for gastric cancer.³ Asian-Pacific guidelines on gastric cancer prevention recommend screening for and eradicating *H. pylori* in high-risk populations.⁵ Importantly, Canadian guidelines also recommend screening for and eradicating *H. pylori* in immigrant populations where the incidence of gastric cancer is high.⁶

The Canadian *Helicobacter* Study Group recently convened a meeting addressing at-risk populations for infection in Canada. In addition to native Canadians, data regarding recent immigrants were extensively reviewed and indicated that immigrant populations were at increased risk.³ *Helicobacter pylori* should be among the infectious diseases selected as high priority for Canadian immigrant guideline development because the majority of immigrants come from high-prevalence regions, which also have an increased risk for gastric cancer. Furthermore, screening tools as well as inexpensive and effective interventions exist to eliminate infection, which could prevent the development of disease complications.

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Canada's low-risk drinking guidelines

In the Nov. 8, 2011, issue of *CMAJ*, Latino-Martel and colleagues¹ suggested that new evidence connecting alcohol consumption and increased risk of cancer means that drinking guideline limits are too high, at least as far as the prevention of cancer is concerned.

As scientific advisors for the forthcoming Canadian guidelines,² we acknowledge the clear evidence that having even one drink per day may significantly increase the risk of cancer if this pattern is maintained over several years. We also acknowledge the importance of communicating this information to consumers. This was considered in our efforts to find a basis for a national consensus to replace the diverse sets of guidelines previously offered by different Canadian provinces.^{3,4}

Has alcohol just now approached the status reached by tobacco over 60 years ago, when the connection between smoking and lung cancer was first established? Consuming alcohol is more complex because low levels of alcohol consumption may increase the risk of many conditions and reduce the risk of others — notably heart disease and diabetes. We relied on evidence from meta-analyses of alcohol consumption and all-cause mortality⁵ to identify a level of consumption at which potential risks and benefits are, for the average person, balanced in comparison with abstainers (i.e., at the ascending portion of the J-shaped curve where risk approached 1.0). The science underlying these studies is not perfect but it does provide a simple and intuitive basis for advice on upper limits for average daily consumption of alcohol (the level at which lifetime risk of premature mortality from all causes does not exceed that of an abstainer). The best available evidence was judged to suggest weekly upper limits of 10 standard drinks for women and 15 for men, so to limit the risk of serious illnesses (note: one Canadian standard

drink contains 17.05 mL ethanol). Recommendations for upper daily limits, strategies to reduce short-term risks associated with drinking, and other recommendations are also provided in an independent scientific report to be published later in 2011.² We strongly agree with Latino-Martel and colleagues¹ that these are low-risk, not *zero* risk, guidelines, and that people deserve complete information about risks and possible benefits of alcohol upon which to make informed decisions.

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When patient and doctor disagree

Physician practice in the area of end-of-life care has been shown in previous investigations to vary considerably. In the study by Sprung and colleagues,¹ religion of the practitioner and geographic location had a material influence on end-of-life decisions. In the Canadian single-payer system, patients in intensive care have little or no ability to select the intensive care unit (ICU) doctor. Patients wrongly assume that all ICU doctors are equivalent with respect to important decision-making. Turgeon and colleagues² reveal that which week a patient arrives in the ICU might mean the difference