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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References

1. MacDonald NE, Flegel K, Hébert PC. Better management of chronic pain care for all [editorial]. *CMAJ* 2011;183:1815.
2. Fischer B, Jones W, Murray K, et al. Differences and over-time changes in levels of prescription opioid analgesic dispensing from retail pharmacies in Canada, 2005–2010. *Pharmacoepidemiol Drug Saf* 2011;20:1269-77.
3. Wenghofer EF, Wilson L, Kahan M, et al. Survey of Ontario primary care physicians' experiences with opioid prescribing. *Can Fam Physician* 2011; 57:324-32.
4. Dhalla IA, Mamdani MM, Sivilotti ML, et al. Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. *CMAJ* 2009;181:891-6.
5. Fischer B, Nakamura N, Rush B, et al. Changes in and characteristics of admissions to treatment related to problematic prescription opioid use in Ontario, 2004–2009. *Drug Alcohol Depend* 2010; 109:257-60.
6. Gomes T, Mamdani MM, Dhalla IA, et al. Opioid dose and drug-related mortality in patients with nonmalignant pain. *Arch Intern Med* 2011;171: 686-91.

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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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References

1. Webster PC. Centralized, nationwide electronic health records schemes under assault. *CMAJ* 2011; 183:E1105-6.
2. Webster PC, Kondro W. Medical data debates: Big is better? Small is beautiful? *CMAJ* 2011; 183:539-40.

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Helicobacter pylori and immigrant health

We read with interest the article by Swinkels and colleagues[1] 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