

Letters to the editor

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Statins: the good, the bad and the ugly

Statins are arguably the most efficacious lipid-lowering drugs available. Many benefits are now considered to emerge from pleiotropic effects other than lipid modification. Novack and coauthors have reported yet another positive lipid effect of statins.¹ Researchers who analyzed the results of the JUPITER trial also showed that rosuvastatin significantly reduced the occurrence of symptomatic venous thromboembolism.² However, the United States Food and Drug Administration (FDA) has recently approved a new safety labelling change for the entire class of drug.³ The FDA has warned that increases in glycosylated hemoglobin (HbA1c) and fasting serum glucose levels have been reported with statin use. Moreover, the FDA has added a safety warning about associated cognitive impairment (e.g., memory loss, forgetfulness, amnesia, memory impairment, confusion).³ We have to bear in mind that statins have numerous interactions with cardiovascular and other drugs that may increase the toxicity of statins.^{3,4}

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Leadership on prescription drugs needed

The article by Michael Law and coauthors raises issues germane to both clinical practice and public policy.¹ After hospitals, drugs comprise Canada's second greatest national health expenditure.² That low-income and chronically ill Canadians struggle to maintain medication adherence is surprising.

The high cost of medications for people with chronic disease may also have effects beyond nonadherence. Patients have told me about sacrifices they have made, such as limiting dental care, child care or even food to afford their prescriptions. The relative benefits of each prescription should be weighed against these possible repercussions. Perhaps patients should be screened for cost-related non-adherence at the time of prescription.

Encouragingly, awareness about the cost of drugs is increasing among clinicians. Some hospitals I have worked at cite antibiotic costs on microbiology reports. Printed resources such as RxFiles³ and the Medication Use Management Services⁴ books are available for office practice. Additionally, drug price guides can be added to electronic medical record systems.

As the authors allude to, public policy is of critical importance and can and should have a role in reigning in nonadherence and expenditure on prescription drugs. A vast gap exists in the Canada Health Act that leaves drug coverage fragmented among the provinces and territories.⁵ Unifying this "patchwork"

could be a cheaper and healthier option. It is time for Canada to follow the example of many other developed nations⁶ and seriously explore a national prescription drug strategy.

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Floater panic could cause overreferral

I enjoyed the summary, "Posterior vitreous detachment, retinal tear and retinal detachment are a spectrum of disease" by Johnson and Hollands in their article "Acute-onset floaters and flashes,"¹ which is part of *CMAJ*'s "Five things to know about ..." series.

I was a bit concerned by the assertion that "[in] 14% of cases, tractional forces ... cause a full thickness retinal tear." This is simply not true if you consider a "case" to be any patient who presents to his or her primary care physician. The data for this statement come from a meta-analysis coauthored by Hollands.² The studies used in the meta-analysis are predominantly of patients referred to retina specialists. Thus the "cases" have been preselected. I am afraid that a naive reader may assume that in all patients presenting for initial evaluation to their family physician with only a symptom of new-onset floaters will have a 14% chance of retinal tears. Thus, the many family physicians who read *CMAJ* may have a

significant problem with overreferral of the all-too-common phenomenon of floaters without flashes. I would love to see a study that shows how likely patients with floaters, who present only to their family physicians, are to have a retinal tear. To my knowledge there is presently no such good information. All of the studies in this area are coming from tertiary care or subspecialty settings.

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The authors respond

Thank you for your response¹ to the “Five things to know about ...” article on acute floaters and flashes in the *CMAJ*.² These points are a summary of

data from a large meta-analysis published in *JAMA* in December 2009.³ The 14% incidence of retinal tears in patients with acute floaters and flashers was indeed patients referred to ophthalmology clinics at tertiary hospitals (but not just to retinal specialists). We agree that there is a selection bias and that this may not necessarily represent the same population of patients who present to the general practitioner with similar symptoms. Many such patients may indeed have long-standing or recent floaters that are benign. Like you, we are not aware of a study that looks at this. However, we believe general physicians need to be aware of the importance of the acute onset of floaters and flashes and the appropriate time frames for referral — especially in cases of field loss, vitreous hemorrhage and subsequent resurgence of symptoms.

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CORRECTION

Incorrect term used

In a synopsis in the May 15 issue,¹ the Editor’s comment mistakenly referred to “irritable bowel disease.” The correct term should have been “inflammatory bowel disease.” *CMAJ* apologizes for this error.

Reference

1. Murdoch TB, Bernstein CN, El-Gabalawy H, et al. Prevalence of genetic variants associated with inflammatory bowel disease in a healthy First Nations cohort. *CMAJ* 2012; 184:E435-41.

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