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Editorial   **Open Access**

Are we Still Treating the Numbers?

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A 47 year old complains that he has muscle cramps and Charley horses on his calves, which he has had for 6 weeks. He believed that his muscle cramp was due to low potassium. Upon further investigation, he reported that his cardiologist had started a statin around the same time as the start of his symptoms. The clinical symptoms and the onset of the symptoms are consistent with statin-induced myositis. A junior family physician requested a battery of laboratory works, which included serum potassium, calcium, phosphate, creatinine kinase and liver functions test. Regardless of the laboratory result, in the absence of other causes in the history, the statin is the most likely culprit and should be discontinued. In the presence of normal creatinine kinase, the statin still would require a trial of discontinuation. Although the result might be confirmatory and interesting, the test has contributed nothing to the decision.

Not long ago, many clinical guidelines such as those for blood pressure and cholesterol were developed to assist clinicians to aim for certain targets. These targets are often laboratory parameters, which assumes they reflect clinical outcomes. Normalizing the targets, it is supposed, will result in good outcomes. As a result, clinicians opt to prescribe more drugs and at higher doses to achieve treat-to-target. This in turn results in even more testing to monitor efficacy and toxicity. In addition, patients are also required to self-monitor and self-manage to reach targets. The increased demand to reach target requires time and effort from patients. This may lead to non-adherence, and poor laboratory results, which reflects poor control. Consequently, the clinicians feel compelled to intensify the dose again leading to patients exposed to increased risk of adverse effect. Yet, the targets were set without evidence to reduce specific composite outcomes such as all cause mortality or cardiac mortality. For example, currently, there are many cardiovascular risk calculators such as the Framingham risk calculator, available to estimate a patient's risk of developing cardiovascular disease. Despite such tools available to assist clinicians in the management of high-risk patients, there are inconsistencies among the calculators [1,2].

Prior to the existence of modern laboratory and radiographic tests, in Traditional Chinese Medicine practice, clinicians treated patients based on symptoms presented and that is still the case in spite of the introduction of modern medicine. Perhaps it is time for all clinicians to effectively use structural interview skills and improve patient-physician interactions, which could result in better health [3].

Reference

1. Allan GM, Nouri F, Korownyk C, Kolber MR, Vandermeer B, et al. (2013) Agreement among cardiovascular disease risk calculators. Circulation 27: 1948- 1956.

2. McCormack J, Banh HL, Allan GM (2014) Refining the American guidelines for prevention of cardiovascular disease. Lancet 383: 598-599.

3. Kaplan SH, Greenfield S, Ware JE Jr (1989) Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Med care 27: S110-127.

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