The Value of Establishing Baselines

John J. Frey, III, MD, Medical Editor

The old saw about not knowing where you are going means that any road will get you there has a corollary—you can't get to a destination unless you know where you are starting. This issue of the *WMJ* includes two articles that help understand the starting point—and trends—for two important Wisconsin-focused clinical issues. The first, from Che and colleagues[1] looks at prescription use by patients statewide, and the second, from Ablove and colleagues,[2] describes the changes in the increased use of a shoulder surgery over a relatively short period of time

We are a pill-using nation, and pressure from society, pharma, and the press tries to identify every social ill from the cold to sleeplessness to erectile dysfunction as a problem that will respond to a pill. Direct-to-consumer advertising, which used to be direct-to-prescriber advertising in medical journals, has increased the likelihood of patients seeking something pharmaceutical for their problems.[3] I remember a patient contacting me about a new drug for obesity that was going to be released by the Food and Drug Administration (FDA) the next day and wondering if he could get a prescription for it. Patients often more closely follow the FDA than clinicians do.

We can't begin to change our prescribing behaviors until we understand the starting point—the baseline—for our practices. Electronic health records should help understand what we do in practice, but health systems rarely report prescribing patterns except when they are a problem—such as narcotic use—and the individual variability in a group is often surprising when we do look at reports. A few years ago, a resident at our clinic brought some studies that showed both the cost and positive effects of chlorthalidone should make it the diuretic of choice for hypertension. Most in our practice changed but then changed again after the third or fourth report of a patient with life-threatening hypokalemia as a result. We either had to add another medication or change to another diuretic. None of the other clinics were using chlorthalidone, and it was not clear to me why we had decided to use it. Regular reports of prescribing profiles would be the source of lots of interesting discussions in group practices.

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So, findings from Che and colleagues are worth reading and talking about. Common medications for cardiovascular, endocrinologic, and respiratory problems—all chronic illnesses—lead the list and, fortunately, the entire list of most-prescribed medications from their study come as generics. They also did not find oxycodone in their top medications, which is surprising, given that chronic pain is becoming one of the more controversial and exasperating problems encountered in primary care. Any list of prescriptions has narcotics in the top 5 most prescribed. But the authors' explanation is enlightening: there are more prescriptions written for narcotics but for a small number of patients from the general population. The database for Che and colleagues is a representative statewide sample of patients, rather than a list from a practice. Their study emphasizes the value of looking at total populations as a starting point, rather than simply our own practices. Their study shows things that should not come as a surprise: that we take more pills as we age, that women take more pills than men, and smokers need more medication than nonsmokers. But their data also show that education, race, and family income are correlated with increased medication use. Social deter-

minants (see the article in this issue by Swain and colleagues[4]) have an effect on health—and one of those effects is on the number and cost of medications to treat problems.

Ablove and colleagues describe the increase in shoulder repair for superior labrum anterior and posterior (SLAP) injuries. A statewide database showed that the number of surgeries for SLAP repairs almost doubled in 8 years. The authors raise a number of concerns about the potential for over-diagnosis of the problem and concerns about the frequency or desirability of surgical repair. While the prevalence of bionic people is increasing and many poorly functioning older adults now walk better on new hips and knees, surgery has obvious risks and the important question is whether the long-term benefits outweigh those risks. It might if you are a major league pitcher with a shoulder injury, but might not if you are a 70-year-old whose golf swing is more restricted than you would like. Rigorous guidelines for both diagnosis and surgical vs nonsurgical treatment of SLAP injuries must be established and followed if we are to achieve the best results for patients. We know, in 2010, where the baseline was. Where should it be in another decade?

Autism in all its forms and variations has become a diagnosis that has been increasing in frequency throughout the country.[5] What was formerly not seen or not recognized is now a common part of the care of a general population. Instead of being a two-box disease—either you have it or you don't—it is a spectrum disorder, which helps clinicians think about the diagnosis more broadly. The use of screening tools for detecting autism spectrum disorders by clinicians who care for children has doubled over the period studied by Keil and her associates.[6] Clinicians who use the screening tools also have established a reliable network of referrals to consultants and to community-based programs, like the Birth to Three Program for at-risk children. It is a reassuring study that demonstrates that giving clinicians the appropriate screening tools results in their using them.

Whenever editors raise the issue of the value of a case report, we find out that they are among the most-used articles in journals, since one of their contributions is to include a mini-review of a subject. As such, whenever we have a group of case reports as we do in this issue, two on atypical presentations or associations and one on an atypical treatment, we find they will be used a great deal over time.[7-9] One of my early teachers said that the most difficult problem I would face would be distinguishing the uncommon from the common cold. Well written case reports, at times, help us make that distinction.

Finally, as 2014 comes to a close, I'd like to extend thanks—on behalf of the *WMJ* Editorial Board and staff—to everyone who reviewed manuscripts for the journal this year. In addition to being an important collegial act, manuscript review is essential to the integrity of *WMJ*. A complete list of reviewers is on p. 213, as well as information about getting involved. If you have served as a reviewer, thank you. If you haven't, please consider doing so in 2015.

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