Access to the Medical Record

TO THE EDITOR: In their editorial (1) on our article (2), Feeley and Shine pose questions to consider as health systems enable patients to access and share their electronic health records. The issues that they raise are relevant and timely, and data emerging from the Veterans Affairs (VA) health care system provide some initial answers.

Patients in the VA health system are embracing opportunities to take ownership of their medical records. In August 2010, President Obama announced the creation of a new “Blue Button” feature on the VA’s personal health record, My HealthVet (3). The Blue Button enables patients to easily download their health information and share it with providers and caregivers.

During the Blue Button’s first year, 311,863 (21%) registered My HealthVet users downloaded their information, suggesting that patients’ interest in sharing their health information is matched by their use of features that facilitate such sharing. Although the VA does not yet enable patients to access encounter notes (contrary to the description in Feeley and Shine’s editorial), this feature has been piloted and there are plans to incorporate it into My HealthVet in 2012.

As with medical care in general, the neediest patients have the most to gain from the coming revolution in personal health records. Sicker veterans are using My HealthVet and—perhaps contrary to the expectations of some—are eager to share their information. A disproportionate number of My HealthVet users are in poor or fair health (40% according to our survey, compared with 24% in the general veteran population) (2, 4), and approximately 79% of these patients expressed interest in sharing their records with a caregiver or provider outside of the VA system (2).

Finally, patients desire control over the specific components of their record that are available to persons with whom they wish to share information. For example, among 4541 patients who expressed interest in sharing their information with non-VA providers in our survey, 57% were interested in sharing their medication lists; however, only 15% were interested in sharing their communications with VA providers (2). This finding suggests a need for tailored applications that allow patients to designate specific portions of their record that selected persons can access.

These early experiences from the VA’s personal health record system provide insight into information-sharing preferences of patients who often have multiple chronic illnesses and psychosocial comorbid conditions—the very patients who may benefit most from a care network enhanced through information-sharing technology.

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Acute and Subacute Neck Pain

TO THE EDITOR: Bronfort and colleagues (1) recently reported a trial intended “[t]o determine the efficacy of spinal manipulation therapy (SMT), medication, and home exercise with advice (HEA)” for neck pain. They concluded that “SMT was more effective than medication” and that “HEA resulted in similar outcomes” as SMT.

I believe that the validity of the comparisons between the SMT or HEA group and the medication group is questionable. The latter group was treated in a different setting with medications that were only loosely described (for example, doses and durations were unspecified). Six participants in the medication group actually received no treatment.

The comparison between the SMT and HEA groups is also problematic. There was no attempt to control for placebo effects, and the contact time between patients and therapists differed considerably. Although the SMT group had an average of 15 “hands-on” treatment sessions of 15 to 20 minutes each, the HEA group had two 1-hour sessions of instructions. Moreover, nonspecific effects of patient–therapist interactions involving touch and verbal and nonverbal communications could have affected the outcome.

In my opinion, reasonable conclusions from the reported data are that different therapeutic settings can lead to different outcomes and that, despite strong, nonspecific effects, SMT is not better than HEA.

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Potential Conflicts of Interest: None disclosed.

Reference
TO THE EDITOR: In Bronfort and colleagues’ recent article (1), it seems to me that the most important conclusion is, “No important differences in pain were found between SMT and HEA at any time point.”

As the study identifies, HEA involved significantly less average involvement from providers than SMT, including fewer than one fifth the number of sessions as SMT, which mainly occurred by telephone and not in the office. Given this and the documented risk for significant adverse outcomes due to vertebral artery dissection in SMT, the principal conclusion from this article must be that HEA offers safety and cost benefits that convincingly establish its superiority over SMT in patients with neck pain.

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Reference

IN RESPONSE: In response to Dr. Ernst, our study was a pragmatic trial designed to assess the comparative effectiveness of 3 commonly used management options for neck pain. The design was chosen to represent as closely as possible what happens in the real-world clinical setting in which treatment is tailored to individual patients (1). Pragmatic trials are not meant to control for placebo and nonspecific effects (different environments, time spent with patients, and others). Control of such effects requires an explanatory or fastidious trial.

As described in the Discussion section of our article, both comparative effectiveness and fastidious trial designs are important but address very different research questions. We made no claim that any of the study treatments was superior to placebo or that the outcomes could not partially be explained by treatment-related, nonspecific effects.

We disagree with Mr. Chapman about the documented risk for significant adverse outcomes related to cervical spine manipulation. The best available evidence about the relationship between spinal manipulation and vertebral artery dissection comes from several large case–control studies (2, 3). These studies show that, although there is an association between visits to chiropractors and the subsequent development of vertebral vascular stroke, this type of stroke is extremely rare. Of importance, the risk is no greater than if patients seek care from their family medical physicians, who are very unlikely to apply spinal manipulation.

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References

OBSERVATION

Bilateral Enlargement of the Lacrimal Glands From IgG4-Related Systemic Disease

Background: Immunoglobulin G4–related systemic disease was first described in 2003. It is a chronic inflammatory disorder defined by the presence of tissue-infiltrating plasma cells bearing IgG4. The association with IgG4 is a relatively recent finding, and the condition has previously been described under numerous other names.

Objective: To increase awareness of this recently described disease to avoid unnecessary investigations and reduce the time to diagnosis.

Case Report: In January 2011, physicians referred a 22-year-old man to our center for lymphadenopathy and lacrimal gland enlargement. His medical history was unremarkable except for removal of a 3-cm submaxillary adenopathy for suspected lymphoma 4 years ago. The pathologic examination showed only nonspecific inflammation.

The patient did not return to the office until 2010, 1 year after he first noticed bilateral lacrimal gland enlargement (Figure). On physical examination, he was in generally good condition but had confirmed lacrinal gland enlargement and several small diffuse lymphadenopathies. Laboratory results were normal or negative for C-reactive protein and β2-microglobulin measurement; antinuclear antibody and antibody to neutrophil cytoplasm assays; HIV and syphilis serologic testing; and renal, liver, pancreas, and thyroid function testing. Eosinophil count (1213/μL) and γ-globulin levels (18.3 g/L, polyclonal) were elevated. Results of tuberculin skin testing and a QuantiFERON-TB Gold (Cellestis, Valencia, California) test were negative.

Because the potential diagnoses included lymphoma, sarcoidosis, and histiocytosis, we obtained biopsy specimens of the cervical mass and found chronic sialadenitis, lymphocytic infiltration, plasma cell infiltration, lymphoid follicles, and fibrosis with an irregularly whorled (storiform) pattern. Bone marrow biopsy results were normal. Orbital computed tomography (CT) and magnetic resonance imaging showed infiltration of the lacrimal gland, extraocular muscles, and fat. Thoracoabdominal computed tomography showed pancreatitis with infiltration and pseudotumors of both kidneys despite the absence of abdominal symptoms. A pancreatic biopsy showed features of autoimmune pancreatitis with lymphoid infiltrate.

Although staining for IgG4 antibodies was negative, we suspected the hyper-IgG4 syndrome on the basis of the lacrimal...
Figure. Lacrimal gland enlargement.

gland enlargement, autoimmune pancreatitis, and pseudotumoral appearance of the kidneys. Serum IgG4 levels were normal (<1.35 g/L). We then stained the lymph node biopsy specimen from 2007 and the salivary gland biopsy specimen for anti-IgG4 antibodies. The IgG4–IgG ratio was 70% for the lymph node and 90% for the salivary gland. We also diagnosed the hyper-IgG4 syndrome with involvement of the lymph nodes, lacrimal glands, periorbital tissues, pancreas, and kidneys and started corticosteroid treatment (prednisone, 0.5 mg/kg daily). One month later, swelling of the eyes and lymph nodes had decreased markedly; 3 months later, abdominal computed tomography showed no pancreatic or renal abnormalities.

Discussion: Most cases of IgG4-related systemic disease come from Asia, but a recent European series has been reported (1). Potentially involved organs include the pancreas, biliary tree, salivary glands, periorbital tissues, pancreas, and kidneys and started corticosteroid treatment (prednisone, 0.5 mg/kg daily). One month later, swelling of the eyes and lymph nodes had decreased markedly; 3 months later, abdominal computed tomography showed no pancreatic or renal abnormalities.

There is no consensus on what number of IgG4-positive plasma cells is significant on biopsy specimens, but the ratio of IgG4–IgG cells ranges from 30% to 40% (2, 3, 5). The Japanese Research Committee for IgG4-related sclerosing disease has proposed diagnostic criteria, which are not yet available in English (3). The treatment mainly includes corticosteroid treatment (2, 3). Immunosuppressive agents can be used for refractory disease (1). Rituximab treatment has shown promising results in some patients (2).

Diagnosis of IgG4-related systemic disease may be challenging, as it was in this case, for at least 2 reasons. First, although different organs can be affected simultaneously, organ involvement starts at different times (3). Second, serum IgG4 levels can be normal before treatment (5).

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References

Retinal Toxicity in Users of “Poppers”

Background: “Poppers” refers to a recreational drug that contains alkyl nitrates. The drug causes a specific maculopathy that is characterized by a faint central yellow spot on fundus photography and disruption of outer segments in central photoreceptors that can be detected with optical coherence tomography (1–3).

Objective: To estimate the prevalence, severity, and predisposing factors of this maculopathy, given the known high and increasing frequency of nitrite inhalant use among teenagers and men who have sex with men (4, 5). For example, 2.4% of teenagers in France used nitrite inhalants at least once in 2000 versus 13.7% in 2008 (5).

Figure.

Retinal Toxicity in Users of “Poppers.”

Letters
Methods: In our medical clinic, we recruited 18 habitual consumers of poppers who did not have ocular signs. Each participant completed a questionnaire and had fundus photography, optical coherence tomography, and measurement of visual acuity.

Findings: All 18 participants were men who had sex with men and had inhaled poppers containing propyl or isopropyl nitrite. Sixteen participants were HIV-positive (mean CD4 cell count, $0.545 \times 10^9$ cells/L [SD, 0.357]). When asked about specific symptoms, 5 participants reported central flashes of light (photopsias) or central areas of partially diminished or entirely degenerated visual acuity (scotomas). Visual acuity was 20/30 or better in both eyes for all 18 participants and 20/20 in 13 eyes.

On fundus examination, we saw a central yellow spot in both eyes of 6 participants and found subfoveal accumulation of hyperreflective material in both eyes of 3 participants. Optical coherence tomography revealed bilateral disruption of reflectivity in the outer retinal layers.
segments of central photoreceptors in both eyes of 10 participants, (Figure) but these findings did not correlate with symptoms or levels of visual acuity.

Participants with maculopathy reported longer mean use of poppers (20.2 years [SD, 9.3]) than those without maculopathy (15.7 years [SD, 7.0]). Those with maculopathy also reported more mean use of poppers per month (2.5 vials [SD, 3.9]) than those without maculopathy (0.5 vials [SD, 0.5]). However, these differences were not significant. Participants with and without maculopathy did not differ in HIV prevalence; CD4 cell count; or use of cannabis, cocaine, alcohol, or cigarettes.

Discussion: We found poppers-associated maculopathy in 20 out of 36 eyes (56%) among 18 habitual users of this drug who did not report ocular symptoms until specifically asked about them. High-resolution optical coherence tomography detected more maculopathy in our participants than the other methods that we used.

The pathophysiology of this maculopathy is not well-understood, although many persons assume that increased levels of retinal nitric oxide and cyclic guanosine monophosphate are involved (2, 3). Our data suggest a dose–effect relationship, although a previous report (3) mentioned one person who developed prolonged maculopathy after use of a single vial of poppers.

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References

Corrections

Correction: Screening for Colorectal Cancer

In a recent guideline (1), the greater-than-or-equal-to symbol (≥) that appears twice in the “High-Value, Cost-Conscious Care” row of Figure 2 should be a greater-than symbol (>). The last sentence of the guideline should read, “Clinicians should not screen adults older than 75 years or those with substantial comorbid conditions . . . .”

Reference

Correction: Dose Response to Vitamin D Supplementation in Postmenopausal Women

The key to Figure 3 of a recent article (1) is incorrect. The dotted line corresponds with BMI of 25.0–29.9 kg/m², and the dashed line corresponds with BMI ≥30.0 kg/m². Also, the Grant Support section of this article should include the Office for Dietary Supplements.

Reference