Patients, hematologists, and time

Two new features, Blood *Consults and Evidence-Based Focused Reviews, add to* Blood*'s continuing efforts to help hematologists access timely, high-quality, and expert information as they encounter the broad range of hematology clinical scenarios.*

In this editorial, we draw attention to 2 new features that will begin appearing regularly in *Blood*: *Blood* Consults and Evidence-Based Focused Reviews. These articles will further augment a number of other recent additions to *Blood*, all aimed at informing and helping hematologists as they encounter the broad range of hematology clinical scenarios. These features include Continuing Medical Education (CME) in *Blood*, How I Treat essays, *Blood*Work images, and Reviews and Perspectives on a wide range of timely topics. Why are the new series being created, and what do all these efforts have in common? Time is the answer.

The practice of hematology shares with medicine and surgery what can be thought of as a main event. This event is so central and powerful that it is invariant: the same in every nation, in every health care system, and in every emergency: a patient, often with loved ones, comes to a clinician for help. This encounter appears simple—but it is not. For a consultation between a patient and a hematologist to occur with the highest quality and value, patients need access. Trained hematologists must exist, supported by a sustainable financial framework. For the highest quality of care, hematologists need rapid access to the latest evidence-based knowledge flowing from discovery and translational research.

In the practice of hematology during the past decade, the flow of knowledge from scientific discovery into patient care has been particularly rapid and paradigm-changing, requiring responsible hematologists to keep up with a myriad of new technologies for diagnosis and patient classification, and multiple new classes of therapeutic agents. *Blood* is one of the only journals in medicine that truly encompasses all aspects of this process, from description of the target biologic pathway, through creation of animal disease models, into early and then pivotal clinical trials. The final important step is to place this information in context for clinical hematologists, helping them efficiently find, understand, and utilize all this new information.

For patients, society, and payers to be assured about quality, it is necessary that hematologists participate in maintenance of certification and licensure, and that they understand and follow evolving metrics being developed and used to measure the quality of practice. Necessary for all of this activity—and under great pressure—is time: time to see the patient, time to think about what to do, time to discuss options with the patient, and time to initiate action. *Blood*, the Committee on Practice, and the American Society of Hematology at large have undertaken these initiatives in *Blood* and through other venues to help hematologists efficiently use their time to learn, maintain their certification and licensure, and positively impact patient care.

One new feature, *Blood* Consults, premieres in this issue on page 2775. This series focuses on very specific clinical issues in a succinct and case-oriented format. The first article in this series titled "*Blood* consult: acute myeloid leukemia and the t(8;21)(q22;22)" has been prepared by Jae H. Park, MD, Cyrus V. Hedvat, MD, PhD, and Martin S. Tallman, MD. It addresses a common anxiety arising in clinicians who manage patients with acute leukemia resulting from the flood of new molecular parameters informing prognosis and thus treatment decisions in acute myeloid leukemia (AML). We probably all know that t(8;21)(q22;22) is a biologic feature associated with better response to therapy, and perhaps most of us remember that this translocation allows classification of this leukemia as a core binding factor AML (CBF AML). But what does it mean if the patient does or does not have a *c-KIT* or an *FLT3* mutation in the presence of this translocation? How important is it to know if the patient has *RUNX1/RUNX1T1*—formerly known as the *AML1/ETO*—rearrangement? And how can one review all of this quickly, so that when one sees his or her next patient, the issues to be considered will spring to mind? This case discussion highlights the major implications resulting from detection of a concurrent *c-KIT* mutation on the management of decisions for patients with t(8;21)(q22;q22).

The second new series, Evidence-Based Focused Reviews, debuts next month and consists of brief reviews of important specific clinical questions, using a standardized and rigorous approach to the grading of evidence and a clear and concise format for the presentation of the material. As all hematologists know, for many clinical encounters the availability of high-quality evidence from randomized trials can be lacking. This is certainly true for the topic of the first evidence-based review: "Perioperative management of patients who are receiving warfarin therapy: an evidence-based but practical approach," written by James D. Douketis, MD, FRCP(C), FACP, FCCP (manuscript in preparation). This scenario can occur at any time—often mixed up in a busy day of consultations and patient care, often via one colleague curb-siding another in the hallway. Where can one get a quick focused review of what to do? This first article addresses cardinal clinical questions including: How to stratify patients according to risk for thromboembolism and bleeding? When is perioperative interruption of warfarin therapy not required? If warfarin interruption is required, when should it be stopped and resumed? If warfarin therapy is stopped, when is heparin bridging required? How should heparin bridging be given before and after surgery, and at what dose? This series' goal is to help clinicians answer such questions based on current evidence.

Updating readers on features that are already established, CME in *Blood* articles first appeared just over a year ago and have been a rapid success. Since January 2010, a total of 12 articles have been linked to CME learning objectives and questions via our partnership with Medscape Education (available at http://www.medscape.org/journal/blood), and have already resulted in a total of 5122 physician-CME encounters, 1761 nurse-CME encounters, and 198 pharmacist-CME encounters. According to Medscape Education, this has been phenomenally rapid and frequent utilization, which speaks to a

previously unmet need for high-quality hematology CME. The How I Treat series, introduced almost 10 years ago, has also been expanding and is a highly popular feature according to our reader surveys, and it receives healthy traffic on the *Blood* website. And finally, hematologists all know that morphology still plays a critical role in the early recognition of blood diseases, for example, the peripheral smear in thrombotic thrombocytopenic purpura and in distinguishing causes of leukoerythroblastic smears—a myeloproliferative disorder or metastatic cancer? The series *Blood*Work provides images to stimulate our eyes and brains and to maintain this crucial but rapidly disappearing skill among practicing hematologists.

We hope that readers will appreciate the sustained effort that *Blood,* the Committee on Practice, the Subcommittee on Quality, and ASH at large have undertaken to help hematologists access critical, high-quality, and expert information efficiently in our society's flagship journal and in other formats. Yet another example of this effort is an initiative just announced to members of ASH by an online message in January 2011. "Hematology Web Focus" is a new effort in the digital world provided by ASH to enhance clinical decision-making and provides a reference tool offering the most timely and relevant published articles and commentaries on an array of hematology-related topics. To investigate this new service, visit www.hematologywebfocus.org. Now, time is short; go read some articles and see some patients!

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