

Journal of General Internal Medicine

Supplement to Instructions for Authors

Capsule Commentaries

Beginning in January, 2010, *JGIM* will publish a new feature called “Capsule Commentaries.” These are brief (≤ 300 words with up to 5 references) companions to Original Research articles that place the work in the context of other theoretical and/or empirical literature, comment upon methodological strengths and weaknesses, and consider the implications of the results for clinical care, education, or research in general internal medicine or primary care. Capsule Commentaries are solicited by the Editors, with the right of first refusal generally accorded to a peer reviewer of the target Original Research Article. Owing to the need for rapid turn-around, Capsule Commentaries will be peer reviewed by the Deputy Editor responsible for the corresponding Original Article and by at least one additional senior editor. Ultimately, most Original Research Articles appearing in *JGIM* will be accompanied by an Editorial or a Capsule Commentary (but not both).

Capsule Commentaries will be formatted as a single article appearing in the print journal just after the Original Research section. Commenting authors will be listed alphabetically in the by-line. The following example, drawing from articles recently published in *JGIM* and commentaries modified from *ACP Journal Club* (which serves a model for this feature), illustrates what the Editors are looking for. We hope that this editorial innovation stimulates scientific dialog while giving peer reviewers an opportunity to share their expertise and critical thinking with a broad audience.

Capsule Commentaries

Carolyn Crandall, A. Niro Siriwardena, Scott M. Stevens, MD, and C. Gregory Elliott, MD

Carolyn Crandall on Politi et al. Revisiting the duration of vasomotor symptoms of menopause: a meta-analysis. (J Gen Intern Med. 2008;23:1507-13.) Vasomotor symptoms are among the most bothersome manifestations of menopause. Although hormone therapy (HT) is effective, concerns about long term side effects (particularly breast cancer and heart disease) have diminished enthusiasm for this approach among physicians and their female patients. Shared decision making about HT is hampered by a lack of information about the longitudinal course of vasomotor symptoms. How long will the symptoms last? How bad will they get? If a woman gets through the first year or two of menopause without resorting to HT, what is her risk of subsequently requiring such therapy?

The meta-analysis by Politi and colleagues is a thorough and rigorous examination of the available data on the time course of vasomotor symptoms in menopause. Unfortunately, the state of the literature in this area leaves much to be desired. In particular, the scant availability of longitudinal studies hampers the assessment of factors influencing VMS prevalence and duration. In addition, the limited data on ethnic and socioeconomic influences on VMS duration is disappointing because African-American women report more of these symptoms than Caucasian women, as do women who are under economic strain (1,2).

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Nevertheless, counseling to address expectations of women in transition to menopause will be substantially influenced by the results of this meta-analysis. The fact that 10% of women report vasomotor symptoms 12 years after the final menstrual period (FMP) will surprise many clinicians. Moreover, the study highlights a message that probably has not been adequately appreciated by clinicians previously: the potential for protracted vasomotor symptoms many years after the FMP. Although less emphasized by the authors, information about the high frequency of vasomotor symptoms among menstruating women will enhance clinical counseling. Politi and colleagues indicate that knowing the expected duration of vasomotor symptoms is a critical factor in determining whether women decide to take HT. However, we cannot yet predict symptom duration in individual women. Moreover, current guidelines advocate HT avoidance in women with preexisting elevated baseline risk for HT-associated adverse events, as well as efforts to discontinue HT at regular intervals (3). These recommendations are unlikely to change based on the results of this study. Because this meta-analysis has documented the potentially long duration of vasomotor symptoms, we must increase efforts to find treatments that are safe for prolonged use. Clinicians looking for information to predict which women are at risk for prolonged vasomotor symptoms can look forward to future reports from longitudinal studies, such as the Study of Women's Health Across the Nation.

Niro Siriwardena on Cepoiu et al. *Recognition of depression by non-psychiatric physicians—a systematic literature review and meta-analysis.* (*J Gen Intern Med.* 2008;23:25-36.) Recognition of depression in primary care can be difficult due to time pressures, competing demands, and tacit patient-doctor collusion leading to prioritization of somatic complaints and diagnoses over psychosocial concerns. The review by Cepoiu and colleagues helps to raise awareness of this problem. However, the authors go too far in suggesting that non-psychiatrist physicians perform poorly, and their argument for developing standardized methods of documentation for depression is questionable.

As the authors state, inclusion of older studies may not reflect current practice. More important, subsyndromal depression was included as “missed” depression. In this situation, the arguments for screening, early diagnosis, or intervention with drugs or formal psychological therapies, such as cognitive-behavioral therapy, are limited (4). Most depression seen in primary care is milder, “fuzzy” (nonprototypical in terms of Diagnostic and Statistical Manual of Mental Disorders, 4th edition, or International Classification of Diseases, 10th revision criteria) in nature, and different from that seen in psychiatric practice. The diagnosis is often negotiated between patient and doctor, depending on whether this label is helpful to recovery (5). In situations where depression may be secondary to undiagnosed physical illness, it is often appropriate and helpful to defer diagnosis, thus preventing medical errors because of premature closure or use of an inappropriate medicalized management pathway.

The gold standards for diagnosis used in these studies were rating scales, which arguably lend themselves better to epidemiologic study than to primary care use. Recent evidence shows that scales used in the United Kingdom to standardize documentation of depression diagnosis and severity may lead to overdiagnosis and overtreatment (6). A recommendation to standardize what is often a socially negotiated diagnosis and management plan may, therefore, be counterproductive, leading to unnecessary medicalization of distress.

Scott M. Stevens and C. Gregory Elliott on Gross et al. The impact of venous thromboembolism on risk of death or hemorrhage in older cancer patients. (*J Gen Intern Med.* 2007;22:321-6.) Clinicians have likened decisions about anticoagulation to walking a tightrope—a misstep to one side increases the risk for bleeding and a misstep to the other increases the risk for thrombosis.

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The study by Gross and confirms that concomitant VTE is an ominous prognostic marker in older patients with some types of cancer and clarifies the mechanism for this observation. Prognosis worsens when VTE accompanies cancer types usually detected at an advanced stage (e.g., pancreas) but not those detected at an early stage (e.g., breast or prostate). Similarly, patients with VTE and certain types of cancer had higher rates of major bleeding, although bleeding did not appear to be the cause of death. Therefore, it seems that the contribution of VTE to cancer mortality relates most to the stage of the underlying malignancy, rather than to VTE or its treatment. The study also highlights the high background risk for major bleeding (7.9%) in older patients with cancer, even in the absence of anticoagulants. This suggests that certain types of cancer should be risk factors in prediction tools for bleeding risk.

Some limitations bear note including lack of pharmacy data and information on quality of warfarin management. Data were obtained before publication of guidelines (7) recommending low-molecular-weight heparin products in lieu of warfarin. The impact of this recommendation on bleeding rates in older cancer patients therefore could not be addressed.

Much work remains to be done. Although we know that the risk for both thrombosis and hemorrhage is higher in older cancer patients than in patients without cancer, we still lack clear guidance on balancing these risks. At present, the results of Gross and colleagues' study should lead clinicians to carefully consider the risks and benefits of anticoagulants in patients with VTE receiving palliation for advanced cancer.

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