Reaching a consensus on irritable bowel syndrome

It is surprising that in spite of a repeatedly stated effort to be patient centered no patients were included as participants in the consensus conference on irritable bowel syndrome[1] for what is so obviously a primary care issue. An oversight?

Russell Springate, MD
Toronto, Ont.

Reference

1. Paterson WG, Thompson WG, Vanner SJ, Faloon TR, Rosser WW, Birtwhistle RW, et al. Recommendations for the management of irritable bowel syndrome in family practice. *CMAJ* 1999;161(2):154-60.

I am surprised that a report from an expert consensus conference on irritable bowel syndrome[1] failed to mention the use of peppermint oil. A MEDLINE search using the key words "peppermint oil and irritable bowel" retrieved 33 817 documents. One particularly interesting study was conducted by Pittler and Ernst in 1998.[2] I agree that there is no level 1 evidence here, or anywhere else. However, as the authors of the consensus conference report mentioned almost everything else that can be used to treat irritable bowel syndrome, they should have included peppermint oil.

Paul Lépine, MD
Ste-Foy, Que.

Competing interests: None declared.

References

1. Paterson WG, Thompson WG, Vanner SJ, Faloon TR, Rosser WW, Birtwhistle RW, et al. Recommendations for the management of irritable bowel syndrome in family practice. *CMAJ* 1999;161(2):154-60.
2. Pittler MH, Ernst E. Peppermint oil for irritable bowel syndrome: a critical review and meta-analysis. *Am J Gastroenterol* 1998;93:1131-5.

[The authors respond:]

We agree with Russell Springate that input from patients suffering from irritable bowel syndrome is very important. However, the purpose of our meeting was to critically examine the current medical literature on the management of irritable bowel syndrome to develop evidence-based guidelines for use by family physicians. A small subgroup of the participants in the consensus conference convened a focus group meeting with a number of patients with irritable bowel syndrome in advance of the conference. The ideas and concerns expressed by these patients were discussed in the small group sessions and taken into consideration as we developed our recommendations.

Paul Lépine points out that we did not mention peppermint oil as one of the antispasmodic agents with potential benefit in the treatment of irritable bowel syndrome. To provide a concise review for family practitioners, we made no attempt to be all inclusive in our discussion of drug therapy, and in fact we did not mention over a dozen other antispasmodic agents that have been subjected to clinical trials in irritable bowel syndrome. It is interesting that although Lépine's MEDLINE search uncovered 33 817 documents on irritable bowel syndrome and peppermint oil, Pittler and Ernst[1] included only 5 double-blind, placebo-controlled, randomized controlled trials in their metaanalysis and they concluded that "in view of the methodological flaws associated with most studies, no definitive judgement about efficacy can be given." This underscores the need, as stated in our paper, for proper prospective randomized controlled trials in irritable bowel syndrome that include well-validated outcome measures.

Competing interests: The Queen's University Gastrointestinal Motility Education Centre is sponsored by an unrestricted educational grant from Janssen–Ortho Inc. Other pharmaceutical sponsors for the consensus conference project were Glaxo Wellcome Inc., Jouveinal Canada Inc., Pfizer Canada Inc., Solvay Pharma, Hoffmann–LaRoche Ltd., and Procter and Gamble Pharmaceuticals Canada Inc. Authors who were not members of the Queen's University Gastrointestinal Motility Education Centre received an honorarium and travel expenses from the centre. Drs. Paterson and Vanner have received speaker fees from Janssen–Ortho unrelated to this consensus conference.

William G. Paterson, MD
Queen's University
Kingston, Ont.
W. Grant Thompson, MD
University of Ottawa
Ottawa, Ont.
Stephen J. Vanner, MD
Queen's University
Kingston, Ont.
Thomas R. Faloon, MD
University of Ottawa
Ottawa, Ont.
Walter W. Rosser, MD
University of Toronto
Toronto, Ont.
Richard W. Birtwhistle, MD
Queen's University
Kingston, Ont.
Janet L. Morse, MD
Thornhill, Ont.
Thomas A. Touzel, MD
Napanee, Ont.

Reference

1. Pittler MH, Ernst E. Peppermint oil for irritable bowel syndrome: a critical review and meta-analysis. *Am J Gastroenterol* 1998;93:1131-5.

To test or not to test

The authors of the clinical practice guideline for management and referral to nephrologists of patients with elevated levels of serum creatinine[1] have a laudable goal of improving the care of people with renal disease. However, I was left a little uncertain as to just what it was they were recommending as the justification for and frequency of serum creatinine tests. Were they recommending this test as part of a periodic health examination or as part of case-finding or population screening?

These recommendations will be interpreted and acted upon by the family physicians in our communities. As a

laboratory physician, I try to provide services within a defined budget and I have to live with recommendations and decisions taken in faraway places.

Roland Jung, MD
Fundy Laboratory Consultants
Kentville, NS

Reference

1. Mendelssohn DC, Barrett BJ, Brownscombe LM, Ethier J, Greenberg DE, Kanani SD, et al. Elevated levels of serum creatinine: recommendations for management and referral. *CMAJ* 1999;161(4):413-7.

[One of the authors responds:]

Roland Jung raises important questions. Neither the Canadian Society of Nephrology nor the Canadian Task Force on Preventive Health Care has issued a directive about whether serum creatinine testing should or should not be included as part of periodic health examinations. Certainly, widespread population screening is not what we are advocating.

Many physicians perform serum creatinine testing as part of a routine panel of biochemical tests, which may be ordered for many different reasons. The guidelines do suggest a case-finding approach in describing characteristics of patients at high risk for renal failure, in whom serum creatinine should be tested. The guidelines are meant to recommend what should happen when an elevated serum creatinine level is discovered in these settings.

The question about frequency of testing is a difficult one to answer. It was considered by the committee but was not included in the guidelines because there are so many factors that must be considered. For example, annual or biannual testing is sufficient if a patient has mild, chronic and relatively nonprogressive renal failure, whereas monthly testing might suffice for a patient with severe chronic renal failure. Weekly or even daily testing might be required for a patient with rapidly progressive glomenulonephritis.

David C. Mendelssohn, MD
University of Toronto
Toronto, Ont.

Should we preach parsimony for health care?

Webster's dictionary defines parsimony as "extreme or excessive economy or frugality; stinginess." Surely Vahé Kazandjian is not serious in suggesting this as a goal in the provision of health care.[1] "Parsimonious" exactly describes the Canadian health care system at present.

Gerald E. Sinclair, MD
Silton, Sask.

Reference

1. Kazandjian, V.A. Power to the people: taking the assessment of physician performance outside the profession. *CMAJ* 1999;161(1):44-5.

[The author responds:]

In my review of the Physician Achievement Review initiative launched in Alberta, I discussed aspects of performance and quality by placing them within the context of quantitative analysis. The spirit of that analysis is to be scientific in its inquiry, implementation, and evaluation. As a guiding principle I proposed that such a series of steps be undertaken with "parsimony" in mind, or parsimoniously.

The golden rule of science is, indeed, that of parsimony. The Law of Parsimony, also called Ockham's Razor, goes back to the 14th century; William Ockham (died *circa* 1349) stated that *non sunt multiplicanda entia praeter necessitatem*, meaning that one should not increase, beyond what is necessary, the number of entities required to explain anything. This law, used sharply by Ockham (hence the razor), assumes that simpler explanations are inherently better than complicated ones. The scientific method of hypothesis generation and testing relies heavily on this powerful tool. In its recommendation to cut to the essence of things, the Law of Parsimony has shaped Western scientific thinking from Galileo to Einstein, who adapted the law as "make things as simple as possible – but no simpler." Epistemological in nature, the principle can be interpreted as saying that simpler models are more likely to be correct than complex ones.

The Law of Parsimony has also been used in the context of the definitions of quality health care in a seminal work by Donabedian.[1] He stated that "the use of redundant care, even when it is harmless, indicates carelessness, poor judgement, or ignorance on the part of the practitioner who is responsible for care. It contravenes the rule of parsimony which has been, traditionally, the hallmark of virtuosity in clinical performance."[1]

The societal dimension of parsimony is also critical to health care: providing the appropriate care, at the appropriate time, without waste is the responsibility of the health care provider, who should take into account both quantitative and qualitative aspects of diagnosis, patient management and resource utilization.

It is within the context of scientific rigor, clarity of causal relationships and appropriate decision-making that I have proposed that we should be "parsimonious." The scientifically trained mind functions at its best when the desk is cluttered but the decision paths are stingily chosen.

Vahé A. Kazandjian, PhD, MPH
President
Center for Performance Sciences
Elkridge, MD

Reference

1. Donabedian A. *Explorations in quality assessment and monitoring, vol. 1. The Definition of quality and approaches to its assessment*. Ann Arbor: University of Michigan Health Administration Press; 1980. p. 29.

What's in a name?

The report by Roanne Segal and colleagues on the Oncology Rehabilitation Program at the Ottawa Regional Cancer Centre[1] is interesting, but they do not describe how this program differs from those designed for other diseases. For the label "Oncology Rehabilitation Program" to be valid, the program should deal specifically