

COMMENTARY**Guest Family Physician Commentaries***William J. Murdoch, MD***Re: Acanthosis Nigricans: High Prevalence and Association with Diabetes in a Practice-based Research Network Consortium—A PRiMarry care Multi-Ethnic Network (PRIME Net) Study**

The high prevalence and associated morbidity and mortality of type 2 diabetes mellitus (T2DM) present a significant challenge for today's family physician at the individual, patient, and public health levels. It follows that the primary and secondary prevention of this disease are of keen interest to clinicians. Kong et al¹ present data about the correlations between acanthosis nigricans (AN) and T2DM, replicating the findings from earlier, limited studies within a multistate primary care research consortium. The study highlights 2 key points that should be of interest to family physicians.

First, although AN was associated with a higher prevalence of T2DM, it did not relate well with the traditional screening modalities currently recommended for the disease. For example, AN showed no significant association with blood pressure, which is used by the US Preventive Services Task Force as the sole screening "trigger" for T2DM.² In addition, fasting blood glucose, currently the standard screening method, was also not correlated with AN. Several questions follow from these findings: Does the use of AN as a screening tool for T2DM present an opportunity to catch the disease process earlier? Would AN predict glycohemoglo-

bin? And, most worrisome, are the current screening standards and methods not as useful as we believe?

Second, the article highlights the importance of a thorough physical examination performed by a knowledgeable clinician. The Continuing Medical Education program designed by the authors to train clinicians on the identification of AN³ would be a useful tool for all family physicians. Indeed, the low cost and noninvasive nature of this potential screening tool (if borne out by further research) would mandate increased education for all clinicians about the recognition and management of AN.

Re: The Rural Older Adult Memory (ROAM) Study: A Practice-based Intervention to Improve Dementia Screening and Diagnosis

The potential benefits and real-world challenges of implementing principles of the patient-centered medical home are illustrated in the study by Boise et al.⁴ Meeting the challenges of a busy, rural primary care practice is a tall order for any clinician; adding the burden of screening for and diagnosis of a subtle process like dementia can seem overwhelming. The authors illustrate how the recruitment of other medical team members to perform functions traditionally reserved for physicians can help alleviate this burden and (potentially) lead to improved patient outcomes.

One of the most notable findings of this study—though not a primary outcome—was the success with which medical assistants were able to incorporate a validated screening tool for a chronic disease into their existing workflow after only a brief, targeted training session. Of further interest was the generally positive response from the assistants to this new level of responsibility. This supports previous literature that demonstrated increased job satisfaction among medical staff after the implementation of clear, team-based roles and responsibilities.⁵

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Clinicians involved in the study were less enthusiastic, with a commonly cited reason paraphrased as, Why screen for a disease we cannot adequately treat? This highlights another key barrier to the implementation of new clinical methods: physicians must see the value in altering our practices or else practicing will not change. An excellent follow-up study to the research presented here might address whether the recognition of dementia by clinicians makes any measurable difference in patient outcomes.

Re: Antidepressant Medication Use for Primary Care Patients with and without Medical Comorbidities: A National Electronic Health Record (EHR) Network Study

Depression frequently complicates the course of many chronic diseases, and some literature suggests improvements in disease outcomes with the concomitant treatment of comorbid depression. The feasibility and effectiveness of such treatments in a primary care setting, however, are not well described. Gill et al⁶ set out to explore the antidepressant prescribing practices of family physicians who are caring for patients with depression and another chronic disease.

The authors specifically address the percentage of depressed patients who received antidepressant medication prescriptions, with “disappointing” results—patients with a comorbid chronic disease were actually less likely to be prescribed a selective serotonin reuptake inhibitor. This supposition, however, omits the option of nonpharmacologic treatment of depression, which often is preferred by primary care patients.⁷ Indeed, cognitive-behavioral therapy is consistently found as efficacious for the treatment of depression as selective serotonin reuptake inhibitors.⁸ It would be interesting to study the total range of depression treatment options rather than only pharmacotherapy options.

The other primary outcome dealt with the concept of “full-dose” antidepressant prescriptions. This seems to be a flawed premise, especially in the context of patients with multiple chronic diseases who presumably are taking multiple medications. The authors do note a potential reluctance on the

part of physicians to “overmedicate” patients, but a more scientific rationale lies in the cytochrome P450 metabolism system in the liver. These patients are likely to be taking several medications competing for the same enzyme; thus, a lower prescribed dose may result in comparable serum levels, and so a therapeutic effect would be present without necessitating the “full dose.” To both outcome measures, the reader would do well to recall that prudent prescribing does not imply failure to treat.

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