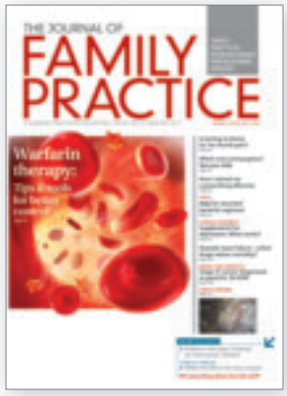
Erratum: Clinical Inquiries



The Clinical Inquiry, "Do NSAIDs impede fracture healing?" (*J Fam Pract.* 2011;60:41-42) incorrectly stated that the American Academy of Family Physicians (AAFP) recommends nonsteroidal anti-inflammatory drugs for pain relief from stress fractures. This recommendation appeared in a review article published in the journal *American Family Physician*; the AAFP does not have a policy on pain relief for fractures.

Gun control editorial should have stuck to the evidence

As physicians, we want to do the right thing, both for individual patients and overall public health. We may endanger the very people we desire to protect, however, if we see every controversial issue through the lens of public health and assume that our medical knowledge and good intentions automatically qualify us to design public policy. The "gun control" debate, addressed by Dr. Susman in his recent editorial, "Locked, loaded—and lethal" (*J Fam Pract.* 2011;60:63), is a case in point.

Sadly, Dr. Susman seems to be on a crusade to rid our society of guns, without having anything other than some Brady group talking points and a gut-level dislike for the National Rifle Association to base it on. Some of us, who certainly share his disgust when innocent people suffer from violence, most certainly do not agree with his plan of action.

We have a fundamental problem when those who crusade for tougher gun laws are not only unaware of the documented problems restrictive legislation has caused domestically,[1] but fail to take into account the biggest human-induced loss of lives worldwide—genocide.

Throughout the 20th century, genocide dwarfed the number of murders and accidents associated with firearms, terrorism, and battlefield deaths combined.[2] Yet genocide never happens where there is widespread possession of serious firearms (what the news media would call "assault weapons") by the citizenry.[3] Even if strict gun laws could prevent the relatively few innocent deaths associated with less restrictive legislation, the increased risk of societal instability, and even genocide, is immeasurably more destructive.

Claiming that an issue is a matter of public health does not make it so. Nor do physicians who abandon objectivity and become emotionally driven gun-control crusaders serve the greater good. Writing off anyone who opposes what may *seem* like common sense gun control ignores reality, and is nothing more than hoplophobic grandstanding at the expense of innocents like Christina Green.

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The vision of the world, illuminated from the glow of an ivory tower, sometimes distorts the reality of the world outside.

Dr. Susman's emotional outburst ignores the multifaceted issues of gun ownership and utilization and is unencumbered by a balanced review of the facts and research (if there were any facts in his editorial at all).

Anybody can have an opinion. What's needed is evidence of a sage and clear thought process to help guide people to rational decisions. We physicians should spread light, not heat. The vision of the world, illuminated from the glow of an ivory tower, sometimes distorts the reality of the world outside.

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Urine drug testing: An unproven risk management tool?

As a member of the editorial board of the *Journal of Pain & Palliative Care Pharmacotherapy*, an author of numerous scholarly articles about chronic pain (some of which

are cited here), and a person who lives with chronic pain, I would like to comment on "Is it time to drug test your chronic pain patient?" (*J Fam Pract.* 2010;59:628-633). Drs. McBane and Weigle recommend the use of pain agreements and drug testing for every patient with noncancer chronic pain, but fail to mention that there is insufficient evidence of the efficacy of both adherence monitoring tools.[1] In addition, a recent article in *The American Journal of Bioethics* recommends against the "universal application of pain agreements" and suggests that they can harm the patient/physician relationship.[2] Consent for drug testing often comes from the pain contract[3]—agreements that have been called "unconscionable adhesion contracts" and may be unenforceable.[4]

The authors also suggest that urine drug testing is noninvasive. Nothing could be further from the truth. Drug testing of people with pain may be considered a suspicionless and warrantless search of bodily fluids and in certain cases may be unconstitutional.[5] There is no question that drug misuse, abuse, addiction, and overdose are devastating to individuals, families, and society. However, using unproven risk management tools that may cause greater harm than good is just bad medicine.

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3. Collen M. Analysis of controlled substance agreements from private practice physicians. *J Pain Palliat Care Pharmacother.* 2009;23:357-364.
4. Collen M. Opioid contracts and random drug testing for people with chronic pain—think twice. *J Law Med Ethics.* 2009;37:841-845.
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Psychiatric symptoms linked to a most unusual cause

We would like to report on a case that highlights the importance of maintaining a high index of clinical suspicion in a patient with sudden onset of psychiatric symptoms. The patient, an obese 44-year-old woman with a history of hypertension, was seen in the emergency room for the acute onset of pressured and disorganized speech, coprolalia, insomnia, sexual disinhibition, and elevated mood.

A review of her history revealed that a month earlier, she had started taking a daily compounding drug (components included artichoke, *Centella asiatica*, chlordiazepoxide, *Rhamnus purshiana*, furosemide, phenolphthalein, *Hoodia gordonii*, and metformin) and hydrochlorothiazide 50 mg once a day, both prescribed by a doctor for peripheral edema.

Blood work showed hyponatremia (120 mmol/L) and hypokalemia (2.8 mmol/L). A computed tomography scan was normal.

The patient was admitted to the hospital and given potassium chloride and electrolytic physiological serum for correction of fluid and electrolyte imbalances, and quetiapine 300 mg once a day. She was discharged 5 days later, with fluid and blood ion balance restored and symptoms resolved. One month later, the quetiapine was stopped. Six months after discharge, she remains asymptomatic, with no functional deficits.

Blood ion imbalance is known to cause behavioral alterations, and cases of hyponatremia-induced mood changes or psychosis have been reported.[1,2] A case of hypokalemia-induced psychosis in a patient with schizophrenia has been reported,[3] but there are no reports of such changes in a nonpsychiatric patient, such as ours.

In our patient, the acute onset and type of symptoms, the absence of previous similar episodes, her age, the blood ion imbalance at admission, and the fast clinical improvement along with blood analytic normalization and the absence of psychiatric symptoms 6 months later support a diagnosis of hyponatremia/hypokalemia-induced hypomania.

Soon after the patient's fluid and blood ion imbalances were restored, her psychiatric symptoms resolved.

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