



EDITOR'S CORNER

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE
(FEBRUARY 2009)**

Q: In the recent COPD module, shouldn't the Canadian Lung Health test in Box 1, read "if you answer 'yes' to any ONE (as opposed to two) of the following questions, talk to your physician about taking a simple breathing test (spirometry)"?

A: The member is correct. The 2008 COPD guidelines actually state that patients should be screened with spirometry if they answer "yes" to ONE question, as opposed to TWO, as it is stated in the module.^{1,2}

However, in looking at this information point and the literature a bit more closely, we believe that it is important to revisit the evidence for this screening recommendation:

- (1) Symptoms of chronic cough and phlegm production are more likely to be due to diagnoses other than COPD (GERD, post-nasal drip).³
- (2) Spirometry results can be inaccurate due to poor coaching, poor effort on the part of the patient, and inaccurate machinery or interpretation.³
- (3) There are conflicting data about whether the use of spirometry is more likely to result in increased smoking cessation rates.^{3,4}
- (4) There are no research data to support early pharmacologic intervention to reduce significant morbidity or progression in patients with mild disease (Canadian Thoracic Society stage 1, or Medical research council grade 1).^{3,4}

A 2006 Agency for Healthcare Research and Quality report suggested that spirometry should be restricted to use in individuals with dyspnea regardless of smoking status.⁴

It is important to confirm the presence of COPD using reliable spirometry in symptomatic individuals prior to prescribing potentially expensive inhaled medication. However, it appears that in terms of its overall impact on both the development and progression of COPD, we should still be focusing our maximum efforts on smoking cessation. – ES/JW

(1) Manno M, Kaplan A. Chronic Obstructive Pulmonary Disease. *PBSG Educational Module* 2009; 17(2):1-18. Hamilton, ON, Foundation for Medical Practice Education.

- (2) O'Donnell DE, Hernandez P, Kaplan A, Aaron S, Bourbeau J, Marciniuk DD et al. Canadian Thoracic Society recommendations for management of chronic obstructive pulmonary disease - 2008 update - highlights for primary care. *Can Respir J* 2008; 15(Suppl A):1A-8A.
- (3) Enright P. The use and abuse of office spirometry. *Prim Care Respir J* 2008; 17(4):238-242. PM:18958360
- (4) Wilt TJ, Niewoehner D, Kim C, Kane RL, Linabery A, Tacklind J et al. Use of spirometry for case finding, diagnosis, and management of chronic obstructive pulmonary disease (COPD). *Evid Rep Technol Assess (Summ)* 2005;(121):1-7. PM:16238364

FITNESS TO DRIVE (FEBRUARY 2009)

Q: With respect to fitness to drive, is the recommended "cutoff" score of 14 on the MMSE that appears in appendix 3 correct? This seems like a severe stage of Alzheimer's disease to use as a threshold. Please advise.



A: Cut-off of 14 is too low, and we apologize for this typographical error. Based on the CMA recommendation, Appendix 3 should read "It is generally accepted that if the MMSE is less than 24, the patient cannot pass as a safe driver."¹ However, this does raise an important point.

Appendix 3 also cautions that the MMSE is "not sensitive enough to test specific skills such as judgment and perception, among others, which are vital for safe driving."¹ A systematic review² reported that a "single clinically usable cutoff score" is unfortunately not available to provide physicians with strong guidance on making decisions about driving capability.

This is supported by a recent review by the UK-DVLA of over 20 years of patient data, which found that some patients with MMSE scores of 24 are definitely dangerous drivers, while others with scores of 20 drove faultlessly (usually patients who had driven buses and trucks for a living) - suggesting that driving can become an almost instinctive skill.³ Most experts advise that the MMSE test be supplemented by tools that test other areas of capability, such as clock-drawing test⁴ or the ruler-drop test for reaction time.⁵ However, on-road driving assessment is generally seen as the ideal means for assessing a driver with cognitive decline.^{6,7}

As a bottom line, Molnar⁵ proposes that clinicians simply ask themselves "Would I get into a car with this person based on my findings?" If not, then they might want to pursue steps to curtail driving as recommended in the module. – DH/AM/JW

- (1) Determining medical fitness to operate motor vehicles: CMA driver's guide. 7th ed. Ottawa, ON: Canadian Medical Association (CMA); 2007.
- (2) Molnar FJ, Patel A, Marshall SC, Man-Son-Hing M, Wilson KG. Clinical utility of office-based cognitive predictors of fitness to drive in persons with dementia: A systematic review. *J Am Geriatr Soc* 2006; 54(12):1809-1824. PM:17198485
- (3) McFarlane A. Fitness to Drive: Editor's Corner. 2009.

- (4) Wang CCKCJ, Schwartzberg JG, Shanklin A.V. Physician's Guide to Assessing and Counseling Older Drivers. American Medical Association, editor. 2003. Washington, DC. National Highway Traffic Safety Administration. Accessed July, 2009. <http://www.ama-assn.org/ama1/pub/upload/mm/433/physiciansintro.pdf>
- (5) Molnar F. Assessment of Fitness-to-Drive in Persons with Dementia. 11 November/December (10):24-26. 2008. 28th Canadian Geriatrics Society Annual Meeting: Main Program. Accessed June 29, 2009.
- (6) Viamonte SM, Ball KK, Kilgore M. A Cost-Benefit Analysis of Risk-Reduction Strategies Targeted at Older Drivers. *Traffic Injury Prevention* 2006; 7(4):352-359.
- (7) Breen DA, Breen DP, Moore JW, Breen PA, O'Neill D. Driving and dementia. *BMJ* 2007; 334(7608):1365-1369. PM:17600026

RESEARCH UPDATE contact Stefanie Roder at 905.525.9140 ext. 22223 roders@mcmaster.ca

THANK YOU to all our PBSG and PBIL members for participating in our study on the Impact of the Learning Environment on Practice Reflection.

This study was part of a two-year research project funded by the Society for Academic Continuing Medical Education (SACME) under the guidance of Dr. Heather Armson, the principal investigator. We are in the last stages of collecting and analyzing data. Look for the report on the outcome of this study in either the fall or spring newsletter.

PBSG Survey 2009

FMPE regularly surveys a portion of the PBSG membership in order to determine those aspects of the program that are working well and identify areas where improvements could be made. Our last membership survey was 2005; we are planning to give PBSG members the opportunity to participate again in the fall 2009 to let us know how they feel about their PBSG learning program and what improvements they would like to see. For more detail, please contact Stefanie Roder, research coordinator, at 905-525-9140 ext. 22223 or roders@mcmaster.ca.

FOUNDATION NEWS AND NOTICES

News on the Board of Directors' Annual Meeting

The 2009 Annual Retreat Day and Board of Directors' Meeting were held in Hamilton, Ontario on June 5th and 6th, 2009, respectively.

During the retreat, the FMPE staff and Directors provided presentations to the Board of Directors on the various programs and support areas. In addition, recognition gifts were handed to staff and Directors who completed 5, 10 and 15 years of service. The Board of Directors spent the afternoon reviewing the mission statements, by-laws and board governance guidelines.

The Annual Board of Directors' meeting included a full day of discussion and decision making on FMPE activities. For a current list of Board members please go to <http://www.fmpe.org/en/contact/board.html>.

FACILITATOR TRAINING WORKSHOPS contact Heather Haywood 800.661.3249 haywood@mcmaster.ca

Fall 2009 (Tentative dates - minimum registration required to proceed)

Saturday, October 17
Hamilton - **Open**

Saturday, October 24
Calgary - **Closed**

Saturday, October 24
Halifax - **Open**

**To avoid disappointment
Book Early!**

UPCOMING MODULES Do you have a module topic suggestion? Send to: fmpe@mcmaster.ca

▪ ACUTE CORONARY SYNDROME: POST MI ▪ ADULT ADHD ▪ DEPRESSIVE DISORDER ▪ ERECTILE DYSFUNCTION

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