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World Journal of Rheumatology
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Telephone: +86-10-85381891
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EDITORIAL

Cautionary note: Electronic medical records, a potential disaster in the making?

Bruce Rothschild

Bruce Rothschild, Biodiversity Institute, University of Kansas, Lawrence, KS 66066, United States
Author contributions: Rothschild B solely contributed to this article.
Correspondence to: Bruce Rothschild, MD, Biodiversity Institute, University of Kansas, Lawrence, KS 66066, United States. bmr@ku.edu
Telephone: +1-785-6151523 Fax: +1-785-5942691
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Abstract

Concern is expressed that electronic medical records may actually compromise care. Reports are electronically collated with patient charts, but when are they examined? Current electronic transmission of results to patients' electronic medical records do not seem to notify of new information. The unknown time from prescription to patient action and the variable time required for individual test performance seem to mandate that a physician attempting to be conscientious would have to examine all sections of every patient medical record in their practice, every day. That is quite inefficient and error-prone. Electronic medical record still contains what appear to be dangerous "bugs" which compromise our ability to provide the care we believe our patients deserve? I remain unsure that outpatient electronic medical records are "ready for prime time."

Key words: Electronic medical records; Impediments to care; Laboratory results; Efficiency; Reports

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ELECTRONIC MEDICAL RECORDS

Independent of the issue of assuring confidentiality, [*e.g.*, exemplified by local on line (web) release of confidential hospital records on 10 000 patients], concern must be expressed that electronic medical records may actually compromise care in the outpatient setting. Especially pertinent to rheumatologists is concern as to how medical records are appended. Reports (laboratory, radiology, procedure, consultation) currently arrive at physician offices by multiple media. They are collated with patient charts, but when are they examined? As most laboratory providers (at least in this area) refuse to provide cumulative reports, the conscientious physician reviewing reports prior to collation is at disadvantage and can easily overlook significant changes of values that are still within "normal limits". Once the reports are collated (placed in patient chart), the physician has the opportunity to examine the report in real time, and compare it with previous results in the patient chart. The alternative is that the provider first sees the results at the patient's next visit. Such an approach risks timely information being buried in the chart, to the detriment of all involved.

LABORATORY RESULTS

Arrival of mailed or faxed reports clearly alerts physicians to new information. Current electronic records and electronic transmission of results to patients' medical records paradoxically do not seem to provide that alert. Results are automatically inserted in separate sections (*e.g.*, laboratory, radiology) of a given patient's record. A major challenge in actually reviewing results is the unknown time from the physician provision of the prescription to when the patient actually "activates" the prescription (*e.g.*, has blood drawn or X-rays taken) and the variable time required for individual test performance. One local hospital offered to delay transmission of results, so they can send all results from a given order in one transmission - unless of course there was an "urgent" value. That is less likely to occur

with automatic electronic transmission of test results, but also would delay the opportunity for timely physician action on values missed or not recognized as significant by the hospital or laboratory. To learn of new information, the provider would have to examine all sections of every patient medical record in their practice, every day. That is quite inefficient and error-prone. The more time spent reviewing records with no new information reduces attentiveness and opportunity to recognize those that do contain new information.

It was said that Winston Churchill had 100 new ideas a day; three of them were good. He had great advisors. If electronic medical records are to be one of medicine's good ideas, they should not aggravate an ongoing problem: Physician distraction by systematic inefficiencies.

Whether they relate to thwarting systematic insurance company-promoted compromise of patient care or to checking every patient's chart every day for any new results, such distractions compromise the ability of the conscientious physician to provide quality care. While we seem to have limited ability to address insurance company "excesses", we still have a modicum of opportunity to control our own house. Therefore, it seems appropriate to comment that the electronic medical record still contains what appear to be dangerous "bugs" which compromise our ability to provide the care we believe our patients deserve? I remain unsure that outpatient electronic medical records are "ready for prime time".

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EDITORIAL

What qualifies as rheumatoid arthritis?

Bruce Rothschild

Bruce Rothschild, Department of Medicine, Northeastern Ohio Medical University, Rootstown, OH 44272, United States
Bruce Rothschild, Biodiversity Institute, University of Kansas, Lawrence, KS 66045, United States
Author contributions: Rothschild B solely contributed to this paper.
Correspondence to: Bruce Rothschild, MD, FACR, Professor of Medicine, Biodiversity Institute, University of Kansas, Lawrence, KS 66006, United States. bmr@ku.edu
Telephone: +1-785-6151523 Fax: +1-785-5942691
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Abstract

Expansion of diagnostic criteria for rheumatoid arthritis and deletion of exceptions increases sensitivity, but at the expense of specificity. Two decades later, modification of criteria included the caveat: "absence of an alternative diagnosis that better explains the synovitis." That puts great faith in the diagnostic skills of the evaluating individual and their perspectives of disease. The major confounding factor appears to be spondyloarthropathy, which shares some characteristics with rheumatoid arthritis. Recognition of the latter on the basis of marginally distributed and symmetrical polyarticular erosions, in absence of axial (odontoid disease excepted) involvement requires modification to avoid failure to recognize a different disease, spondyloarthropathy. Skeletal distribution, pure expression of disease in natural animal models and biomechanical studies clearly rule out peripheral joint fusion (at least in the absence of corticosteroid therapy) as a manifestation of rheumatoid arthritis. Further, such studies identity predominant wrist and ankle involvement as characteristic of a different disease, spondyloarthropathy. It is important to separate the two diagnostic groups for epidemiologic study and for clinical diagnosis. They certainly differ in their pathophysiology.

Key words: Rheumatoid arthritis; Spondyloarthropathy; Ankylosis; Accelerometry; Animal models

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INTRODUCTION

Perhaps the most problematic challenge to clinical diagnosis has been the 1987 revised criteria[1] for rheumatoid arthritis. It discarded the diagnostic exclusions portion of previous criteria[2], such that sensitivity may have been increased, but at the expense of specificity. The result has been a tendency[3-5] to group all individuals with a predominantly non-axial inflammatory arthritis in this rheumatoid arthritis category. The 1987 criteria do not address the nature of erosions, their specific distribution and the issue of joint ankylosis, characteristics which separate the those newly diagnosed (according to the criteria) as having rheumatoid arthritis into two groups. Such a binary approach[6-9] divides criteria-fulfilling individuals according to location of erosions on or around joints, skeletal distribution of erosions and presence or absence of reactive new bone formation and joint ankylosis. The 2010 criteria[10] address this question by the inclusion "absence of an alternative diagnosis that better explains the synovitis." These are clinical criteria designed to identify individuals who may have early rheumatoid arthritis. Their sensitivity and specificity seem predominantly determined by the clinician's ability to recognize evidence of alternative diagnoses.

The archeologic record provides unique insight to this question of the more generally applied 1987 criteria's specificity, as two segregated patterns of disease are observed. Rheumatoid arthritis is clearly recognized in 7 populations as the only polyarticular inflammatory disease present[11]. The erosions are marginal to joint surfaces' ankylosis is absent; metacarpal phalangeal joint involve-

ment is prominent and periarticular osteopenia, invariably present. This contrasts with other archeological sites, in which erosions, while polyarticular, are more usually limited in distribution, are predominantly subchondral in distribution, ankylosis is present, wrist and ankle involvement are prominent and periarticular osteopenia is absent in more than 50%[6,12-22]. The neologism "osseotropism" was introduced[23] to characterize the tendency of specific diseases to affect such specific areas of the musculoskeletal system. The characteristics of the second group of individuals were indistinguishable from other individuals in those same populations with spondyloarthropathy diagnosed on the basis of axial disease (sacroiliac joint erosions or fusion, syndesmophytes, or zygapophyseal joint erosion or fusion)[12,13,16,21,24]. Fusion of joints through the articular surface (ankylosis) is not surprising in a disease that primarily erodes subchondral bone. This exposes trabeculae, allowing growth across the joint, a process quite different than what is observed in true rheumatoid arthritis.

The two groups also have very different smoothness of movement or resistance of the joint surface to transitional movement, as determined by accelerometer studies. That translates joint movement into a quantifiable electric impulse, providing a measure of vibration intensity/power[25]. Individuals with periarticular osteopenia and symmetrical polyarticular marginal erosions, but no axial disease or peripheral joint fusion (classical rheumatoid arthritis) had low vibration/power, while those with subchondral erosions and/or peripheral joint fusion had high vibration/power. Individuals with spondyloarthropathy, diagnosed on the basis of axial disease, showed the same high vibration/power[25-27].

While it has been suggested that some dogs and pigs had rheumatoid arthritis[28-32], the presence of subchondral erosions and joint fusion[16,21,23,24] are actually more characteristic of spondyloarthropathy[33,34]. Indeed, evaluation of over 30 000 non-human mammalian skeletons reveals many cases of spondyloarthropathy, but not a single instance of actual rheumatoid arthritis[6,14,35-39]. There clearly are two distinct groups that fulfill the revised criteria for rheumatoid arthritis.

The archeologic record, biomechanical studies and the presence of only one of the varieties of this so-called "rheumatoid arthritis" in animals all support the contention that the revised criteria have limited value in distinguishing these groups, as Silman[9] previously suggested. The article by Can *et al*[40] illustrates this quite well. It describes a high frequency of spondyloarthropathy in patients who fulfill the 1987 criteria for rheumatoid arthritis. While it suggests two coexisting diseases, the more parsimonias interpretation is that the diagnosis of rheumatoid arthritis was incorrect in those patients. Robinson *et al*[41] suggest a third, unrelated group, but use the narrow comparison with ankylosing spondylitis, rather than the more general spondyloarthropathy categorization. These opinion pieces emphasize the importance of separating at least the two diagnostic groups segregated herein for epidemiologic study and for clinical diagnosis. They certainly differ in their pathophysiology.

CONCLUSION

Rheumatoid arthritis and spondyloarthropathy are clearly different disorders, distinguished by clinical appearance, radiologic findings, pathophysiology, biomechanical characteristics and representation (or lack thereof) in the zoological record. The significance of biochemical and inflammatory markers is difficult to assess, as rheumatoid arthritis criteria utilized in its classification are insufficiently specific. The tendency to group all individuals with a predominantly non-axial inflammatory arthritis as having rheumatoid has compromised any comparisons, as it also includes many with spondyloarthropathy. The neologism "osseotropism" was presented, to categorize the joint specificity of the two diseases, to facilitate discriminating between them. Utilizing the criteria of joint distribution, presence or absence of subchondral erosions or peripheral joint fusion, analysis of biochemical and inflammatory laboratory markers may provide additional insights at to the vary different pathophysiological processes represented by these phenomena.

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World Journal of Rheumatology (*World J Rheumatol*, *WJR*, online ISSN 2220-3214, DOI: 10.5499) is a peer-reviewed open access (OA) academic journal that aims to guide clinical practice and improve diagnostic and therapeutic skills of clinicians.

Aim and scope

WJR covers topics concerning osteoarthritis, metabolic bone disease, connective tissue diseases, antiphospholipid antibody-associated diseases, spondyloarthropathies, acute inflammatory arthritis, fibromyalgia, polymyalgia rheumatica, vasculitis syndromes, periarticular rheumatic disease, pediatric rheumatic disease, miscellaneous rheumatic diseases, and rheumatology-related therapy, pain management, rehabilitation.

We encourage authors to submit their manuscripts to *WJR*. We will give priority to manuscripts that are supported by major national and international foundations and those that are of great basic and clinical significance.

WJR is edited and published by Baishideng Publishing Group (BPG). BPG has a strong professional editorial team composed of science editors, language editors and electronic editors. BPG currently publishes 42 OA clinical medical journals, including 41 in English, has a total of 15 471 editorial board members or peer reviewers, and is a world first-class publisher.

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The columns in the issues of *WJR* will include: (1) Editorial: The editorial board members are invited to make comments on an important topic in their field in terms of its current research status and future directions to lead the development of this discipline; (2) Frontier: The editorial board members are invited to select a highly cited cutting-edge original paper of his/her own to summarize major findings, the problems that have been resolved and remain to be resolved, and future research directions to help readers understand his/her important academic point of view and future research directions in the field; (3) Diagnostic Advances: The editorial board members are invited to write high-quality diagnostic advances in their field to improve the diagnostic skills of readers. The topic covers general clinical diagnosis, differential diagnosis, pathological diagnosis, laboratory diagnosis, imaging diagnosis, endoscopic diagnosis, biotechnological diagnosis, functional diagnosis, and physical diagnosis; (4) Therapeutics Advances: The editorial board members are invited to write high-quality therapeutic advances in their field to help improve the therapeutic skills of readers. The topic covers medication therapy, psychotherapy, physical therapy, replacement therapy, interventional therapy, minimally invasive therapy, endoscopic therapy, transplantation therapy, and surgical therapy; (5) Field of Vision: The editorial board members are invited to write commentaries on classic articles, hot topic articles, or latest articles to keep readers at the forefront of research and increase their levels of clinical research. Classic articles refer to papers that are included in Web of Knowledge and have received a large number of citations (ranking in the top 1%) after being published for more than years, reflecting the quality and impact of papers. Hot topic articles refer to papers that are included in Web of Knowledge and have received a large number of citations after being published for no more than 2 years, reflecting cuttingedge trends in scientific research. Latest articles refer to the latest published high-quality papers that are included in PubMed, reflecting the latest research trends. These commentary articles should focus on the status quo of research, the most important research topics, the problems that have now been resolved and remain to be resolved, and future research directions. Basic information about the article to be commented (including authors, article title, journal name, year, volume, and inclusive page numbers; (6) Minireviews: The editorial board members are invited to write short reviews on recent advances and trends in research of molecular biology, genomics, and related cutting-edge technologies to provide readers with the latest knowledge and help improve their diagnostic and therapeutic skills; (7) Review: To make a systematic review to focus on the status quo of research, the most important research topics, the problems that have now been resolved and remain to be resolved, and future research directions; (8) Topic Highlight: The editorial board members are invited to write a series of articles (7-10 articles) to comment and discuss a hot topic to help improve the diagnostic and therapeutic skills of readers; (9) Medical Ethics: The editorial board members are invited to write articles about medical ethics to increase readers' knowledge of medical ethics. The topic covers international ethics guidelines, animal studies, clinical trials, organ transplantation, *etc.*; (10) Clinical Case Conference or Clinicopathological Conference: The editorial board members are invited to contribute high-quality clinical case conference; (11) Original Articles: To report innovative and original findings in rheumatology; (12) Brief Articles: To briefly report the novel and innovative findings in rheumatology; (13) Meta-Analysis: To evaluate the clinical effectiveness in rheumatology by using data from two or more randomised control trials; (14) Case Report: To report a rare or typical case; (15) Letters to the Editor: To discuss and make reply to the contributions published in *WJR*, or to introduce and comment on a controversial issue of general interest; (16) Book Reviews: To introduce and comment on quality monographs of rheumatology; and (17) Autobiography: The editorial board members are invited to write their autobiography to provide readers with stories of success or failure in their scientific research career. The topic covers their basic personal information and information about when they started doing research work, where and how they did research work, what they have achieved, and their lessons from success or failure.

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Please list 5-10 key words, selected mainly from *Index Medicus*, which reflect the content of the study.

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Please write a summary of less than 100 words to outline the most innovative and important arguments and core contents in your paper to attract readers.

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For articles of these sections, original articles and brief articles, the main text should be structured into the following sections: INTRODUCTION, MATERIALS AND METHODS, RESULTS and DISCUSSION, and should include appropriate Figures and Tables. Data should be presented in the main text or in Figures and Tables, but not in both.

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Acknowledgments

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Format

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Chinese journal article (list all authors and include the PMID where applicable)

2 **Lin GZ**, Wang XZ, Wang P, Lin J, Yang FD. Immunologic effect of Jianpi Yishen decoction in treatment of Pixu-diarrhoea. *Shijie Huaren Xiaohua Zazhi* 1999; **7**: 285-287

In press

3 **Tian D**, Araki H, Stahl E, Bergelson J, Kreitman M. Signature of balancing selection in Arabidopsis. *Proc Natl Acad Sci USA* 2006; In press

Organization as author

4 **Diabetes Prevention Program Research Group**. Hypertension, insulin, and proinsulin in participants with impaired glucose tolerance. *Hypertension* 2002; **40**: 679-686 [PMID: 12411462 PMCID:2516377 DOI:10.1161/01.HYP.0000035706.28494.09]

Both personal authors and an organization as author

5 **Vallancien G**, Emberton M, Harving N, van Moorselaar RJ; Alf-One Study Group. Sexual dysfunction in 1, 274 European men suffering from lower urinary tract symptoms. *J Urol* 2003; **169**: 2257-2261 [PMID: 12771764 DOI:10.1097/01.ju.0000067940.76090.73]

No author given

6 21st century heart solution may have a sting in the tail. *BMJ* 2002; **325**: 184 [PMID: 12142303 DOI:10.1136/bmj.325.7357.184]

Volume with supplement

7 **Geraud G**, Spierings EL, Keywood C. Tolerability and safety of frovatriptan with short- and long-term use for treatment of migraine and in comparison with sumatriptan. *Headache* 2002; **42** Suppl 2: S93-99 [PMID: 12028325 DOI:10.1046/j.1526-4610.42.s2.7.x]

Issue with no volume

8 **Banit DM**, Kaufer H, Hartford JM. Intraoperative frozen section analysis in revision total joint arthroplasty. *Clin Orthop Relat Res* 2002; (**401**): 230-238 [PMID: 12151900 DOI:10.1097/00003086-200208000-00026]

No volume or issue

9 Outreach: Bringing HIV-positive individuals into care. *HRSA Careaction* 2002; 1-6 [PMID: 12154804]

Books

Personal author(s)

10 **Sherlock S**, Dooley J. Diseases of the liver and billiary system. 9th ed. Oxford: Blackwell Sci Pub, 1993: 258-296

Chapter in a book (list all authors)

11 **Lam SK**. Academic investigator's perspectives of medical treatment for peptic ulcer. In: Swabb EA, Azabo S. Ulcer disease: investigation and basis for therapy. New York: Marcel Dekker, 1991: 431-450

Author(s) and editor(s)

12 **Breedlove GK**, Schorfheide AM. Adolescent pregnancy. 2nd ed. Wieczorek RR, editor. White Plains (NY): March of Dimes Education Services, 2001: 20-34

Conference proceedings

13 **Harnden P**, Joffe JK, Jones WG, editors. Germ cell tumours V. Proceedings of the 5th Germ cell tumours Conference; 2001 Sep 13-15; Leeds, UK. New York: Springer, 2002: 30-56

Conference paper

14 **Christensen S**, Oppacher F. An analysis of Koza's computational effort statistic for genetic programming. In: Foster JA, Lutton E, Miller J, Ryan C, Tettamanzi AG, editors. Genetic programming. EuroGP 2002: Proceedings of the 5th European Conference on Genetic Programming; 2002 Apr 3-5; Kinsdale, Ireland. Berlin: Springer, 2002: 182-191

Electronic journal (list all authors)

15 Morse SS. Factors in the emergence of infectious diseases. Emerg Infect Dis serial online, 1995-01-03, cited 1996-06-05; 1(1): 24 screens. Available from: URL: http://www.cdc.gov/ncidod/eid/index.htm

Patent (list all authors)

16 **Pagedas AC**, inventor; Ancel Surgical R&D Inc., assignee. Flexible endoscopic grasping and cutting device and positioning tool assembly. United States patent US 20020103498. 2002 Aug 1

Statistical data

Write as mean ± SD or mean ± SE.

Statistical expression

Express *t* test as *t* (in italics), *F* test as *F* (in italics), chi square test as χ^2 (in Greek), related coefficient as *r* (in italics), degree of freedom as υ (in Greek), sample number as *n* (in italics), and probability as *P* (in italics).

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Italics

Quantities: *t* time or temperature, *c* concentration, *A* area, *l* length, *m* mass, *V* volume.
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