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UTILISATION OF STATINS IN A CARDIOLOGY OUTPATIENT CLINIC

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Large clinical trials have demonstrated the benefits of statins in preventing coronary events. However, treatment with statins is expensive and long term. Therefore, the utilisation of statins in the Cardiology Clinic at Sai Ying Pun Hospital was audited for 4 weeks in October-November 1996, and in June 1997:

	Oct-Nov 1996		June 1997	
Total no. of statin prescriptions	104		109	
No. of case notes retrieved	99		97	
Male/female	60/39		52/45	
Age (mean, range)	65, 40 - 83		66, 34 - 86	
% with ischaemic heart disease	89		90	
% with risk factors but not IHD	7		4	
% with hyperlipidaemia only	3		3	
pre-treatment total cholesterol (mmol/l)	M 6.0±0.7	F 6.6±1.1	M 6.0±1.2	F 6.8±1.5
pre-treatment LDL-C (mmol/l)	M 4.1±0.4	F 4.7±1.2	M 3.6±0.7	F 4.0±1.0

In one-third of patients, there were no recent lipid profiles or only one lipid measurement before treatment. Only 14% of patients had 2 measurements of LDL-C and only 11% had two measurements of HDL-C before statins were started. Correlation between lipid profiles performed on separate occasions was moderate (r = 0.49, 0.64, for total cholesterol, LDL-C respectively), showing that treatment based on a single measurement is illogical.

In conclusion, decisions to initiate treatment with statins were frequently based on inadequate information. A trial of diet and two lipid profiles will identify better those patients who need long term treatment with lipid lowering drugs. This audit highlights the need to follow lipid-lowering guidelines whenever appropriate.

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AN AUDIT OF MEDICAL RECORDS OF INPATIENTS DISCHARGED

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A random sample of 30 patients was selected from those who were discharged or died (not transferred) from the Dept of Medicine's wards in June 1998. Corresponding medical records were retrieved and scrutinized and relevant information was recorded and collated. The whole exercise was endorsed by the Hong Kong Hospital Authority and the Department of Medicine, and confidentiality was strictly maintained. The records referred to 15 males and 15 females, the mean (± SD) and median age of the sample was 58 (±19), and 63 years respectively. The sample was drawn from a pool of 2081 (Home 1548; died 28; DAMA (discharged against medical advice) 35; transferred 470) listed as discharged by the Department's Records Office. It took 16 weeks to retrieve all the notes through the hospital Records Office. Salient features pertinent to 'due process' and 'documentation' gleaned from the inpatient notes and printed discharge summaries are shown in the table.

			In-patient Notes n (%)	Discharge Summaries n (%)
Due process	i)	Current working diagnosis/problem stated	27 (90)	25 (83)
	ii)	Change of status detailed	16 (53)	14 (47)
Documentation	i)	Important past history/operationsn detailed	26 (87)	23 (77)
	ii)	Major investigation(s) documented	9 (30)	10 (33)
	iii)	Significant intervention(s) detailed	16 (53)	14 (47)

Medication administration records detailed drugs by their trade names in 50% of the instances but none of them mentioned any drug 'allergy'. Regarding discharge summaries, 10 did not include the date of discharge, 5 were unsigned and 24 entailed specialist abbreviations (none of which were defined). Discharge medications and doses were properly itemized in 22 of the summaries and 27 provided adequate details about follow up arrangements.

To enhance communication and understanding, doctors should ensure that patient notes and discharge summaries include all relevant information. If there is 'no drug allergy', this should be documented and standardized abbreviations (by specialty) could be listed on the back of discharge summary sheets.