

UCP1 mRNA was detected with the use of quantitative real-time PCR.¹ Unfortunately, no data regarding UCP1 protein levels or histologic studies are presented. In our view, this information is essential before any conclusions can be made regarding the potential involvement of Buffalo hump–derived brown adipose tissue in the regulation of energy expenditure in patients who have lipodystrophy associated with HIV-1 infection and HAART. To determine whether such patients have signs of enhanced cold-induced glucose uptake in the supraclavicular paracervical region, which our study showed is linked to the presence of bona fide brown adipose tissue, we performed

PET–CT in two such patients (both women). No signs of cold-induced glucose uptake could be identified (Fig. 1).

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Electronic Health Records in Hospitals

TO THE EDITOR: In their study of the use of electronic health records, Jha et al. (April 16 issue)¹ report that only 1.5% of U.S. hospitals have comprehensive electronic-records systems, and 7.6% have a basic system that includes a capacity to store physicians’ notes and nursing assessments in at least one clinical unit. Interestingly, doctors overwhelmingly say that electronic-records systems improve care,² a view that is borne out by the Veterans Health Administration (VHA) experience.³ Nevertheless, very few U.S. physicians use electronic health records. The reasons range from cost to the lack of a national standard.²

The VHA already has an excellent system, the Computerized Patient Record System (CPRS), which has been successfully used for the past 10 years to manage the care of approximately 8 million veterans.⁴ This system is highly reliable, and because it is government shareware, it is available free of charge (www1.va.gov/cprsdemo). The only criticism I have heard about CPRS is that it does not allow for billing, which is something that could be added. CPRS should be made the nationwide standard tomorrow or, better yet, today.

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TO THE EDITOR: Jha et al. have provided an important incremental advance in our knowledge regarding the use of electronic health records in U.S. hospitals. The authors did not include an anesthesia information management system (AIMS) in their definition of either a comprehensive inpatient electronic health record or a basic electronic record. This is an important omission. An AIMS is the anesthesia component of an inpatient electronic health record.¹ As such, it is the electronic record for a high-risk and expensive episode of inpatient clinical care. Approximately 30% of U.S. hospital admissions involve surgical care.²

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TO THE EDITOR: Jha et al. do not address the question of the preservation of patients’ confidential information. As Gillon wrote, “The prin-

ciple of medical confidentiality is one of the most venerable moral obligations of medical ethics."¹ And years ago, Siegler was "astonished to learn that at least 25 and possibly as many 100 health professionals at our university hospital had access to the patient's record."² Will not the adoption of electronic medical records further increase the number of people with access to those charts?

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THE AUTHORS REPLY: We agree with Lipschutz that most physicians, once they overcome the challenges of adoption, are happy with the use of electronic health records. Furthermore, the system that the VHA uses is an excellent tool. It is clinically intuitive and has all the features necessary to allow clinicians to deliver high-quality care. Whether it is the right solution for every physician and hospital in the United States is less clear. However, given that the system is free and familiar to many clinicians, many providers may see this as an attractive solution.

With respect to the issue raised by Mueller and

Trentman about anesthesia information systems: we agree that such systems are likely to be helpful for managing the care of high-risk patients. There are other such "specialized" solutions, including information systems in cardiac suites and operating rooms, which are also likely to be valuable for hospitals. Unfortunately, the scope of our survey limited our ability to examine these areas.

Finally, Miziara expresses concern about privacy, which is on the minds of many clinicians and patients as we transition to the widespread use of electronic health records. In contrast to paper-based records, which are highly insecure, enormous focus has been placed on establishing privacy and security standards for electronic records under the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA). Indeed, as recently as February 2009, Congress further strengthened HIPAA to ensure the privacy of health information.

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Myocarditis

TO THE EDITOR: Supportive care is the mainstay of therapy for acute myocarditis. In his review article on this topic, Cooper (April 9 issue)¹ notes that studies of immunosuppressive therapy have not shown a clear beneficial role, as compared with usual care. Thus, the beneficial effect of immunosuppressive therapy remains controversial. Treatment that is based on the presence of human leukocyte antigen may be associated with improved outcomes.¹ However, are there other ways to predict who is likely to benefit from immunosuppressive therapy? In one trial, prednisolone that was administered to patients who did not have a response to other treatment or whose clinical condition worsened with virus-negative inflammation had the best clinical and echocardiographic outcomes.² In another study of patients with myocarditis in whom conventional

supportive therapy failed, the overwhelming majority of those who did not have a response to immunosuppressive therapy were found to have viral genomes in biopsy specimens and no cardiac autoantibodies.³ The authors of that study concluded that patients "with circulating cardiac autoantibodies and no viral genome in the myocardium are the most likely to benefit from immunosuppression."³ Thus, physicians should be aware of studies suggesting that patients with virus-negative myocarditis may benefit from immunosuppressive therapy.

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