Factors that may influence the likelihood that a provider will have this discussion include their understanding of the risks of medical imaging, the amount of time that is available with the patient prior to ordering a test, concerns related to prior false-negative imaging examination findings, and unfavorable outcomes related to a past approach to an incidentaloma. We found that most frontline providers in our study had very little training in the potential radiation risks from medical imaging and that these providers felt uncomfortable discussing the risks with patients. Alternatively, providers who feel comfortable may choose not to discuss the risks with patients for other reasons, such as relatively small perceived risk compared with the perceived benefits or time limitations. As further dialogue ensues about how to communicate with patients about the risks of medical testing, consideration should be given to the infrequency of these discussions in current practice. Future studies should investigate other potential reasons that providers are not engaging in these discussions and evaluate interventions to increase the frequency and efficacy of these discussions.

Chad Stickrath, MD
Jeffrey Druck, MD
Nathan Hensley, MD
Thomas M. Maddox, MD
Daniel Richlie, MD

Published Online: June 4, 2012. doi:10.1001/archinternmed.2012.1791

Author Affiliations: Divisions of General Internal Medicine (Drs Stickrath and Richlie) and Cardiology (Dr Maddox), Department of Medicine, Department of Emergency Medicine (Dr Druck), and Department of Radiology (Dr Hensley), University of Colorado Denver School of Medicine, Denver; and Denver VA Medical Center, Denver (Drs Stickrath, Hensley, Maddox, and Richlie).

Correspondence: Dr Stickrath, Denver VA Medical Center, 1055 Clermont St (111), Denver, CO 80220 (Chad.stickrath@va.gov).

Author Contributions: Drs Stickrath and Richlie had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Stickrath, Druck, and Richlie. Acquisition of data: Stickrath, Druck, and Hensley. Analysis and interpretation of data: Stickrath, Maddox, and Richlie. Drafting of the manuscript: Stickrath, Druck, and Hensley. Critical revision of the manuscript for important intellectual content: Stickrath, Druck, Hensley, Maddox, and Richlie. Statistical analysis: Druck. Administrative, technical, and material support: Stickrath, Druck, and Richlie. Study supervision: Stickrath, Hensley, Maddox, and Richlie.

Financial Disclosure: None reported.

Additional Contributions: Allan Prochazka, MD, contributed to the design of the study and assisted with the statistical analysis; Howard Li, MD, contributed to the recruitment of participants and assisted with interpretation of the results; and Tanner Caverly, MD, contributed to the interpretation of the results and assisted with editing and preparing the manuscript.


2. Redberg RF. Cancer risks and radiation exposure from computed tomographic scans: how can we be sure that the benefits outweigh the risks? Arch Intern Med. 2009;169(22):2049-2050.

See also page 1035

For DMAA to be legally sold as a dietary supplement, it must be a naturally occurring substance with a documented history of use prior to 1994. Remarkably, the evidence to support the sale of DMAA-containing supplements hinges on a single study. For this single study, published in the now defunct Journal of the Guizhou Institute of Technology, geranium oil (extracted from the fresh leaves and stems of Pelargonium graveolens) was found to contain less than 0.7% DMAA based on a gas chromatography and mass spectrometry analysis. The researchers do not describe their methodology but presumably based their conclusions on matching an unknown peak spectrum of geranium oil with the library mass spectrum of DMAA. The appropriate confirmatory test, using a standardized preparation of DMAA to confirm its presence, was not described.

Since the publication of this study, more than a half-dozen peer-reviewed reports have been unable to confirm this finding. Health Canada, for one, has concluded that “there is no credible scientific evidence that DMAA is captured as an isolate of a plant.” This lack of evidence has not deterred multiple supplement companies from marketing DMAA as if it were isolated from geranium. For example, the popular Jack3d product (USPlabs) sold at GNC (General Nutrition Centers) is labeled as containing “1,3-dimethylamylamine (Geranium [Stem])” (label available from the author on request).

DMAA as a Dietary Supplement Ingredient

The pharmaceutical amphetamine derivative 1,3-dimethylamylamine (DMAA) was introduced in 1948 as a nasal inhaler for rhinitis by Eli Lilly & Co. By the 1970s, it had been withdrawn as an approved pharmaceutical. Surprisingly, DMAA is currently used as an ingredient in roughly 200 sports supplements, many sold in major franchises throughout the United States, with sales topping $100 million in 2010 alone (Table).
Given its wide availability, physicians should understand DMAA’s potential health effects. Supplements containing DMAA have been implicated as potentially contributing agents in multiple serious adverse events, including panic attacks, seizures, stress-induced cardiomyopathy, and 2 deaths. In Europe and New Zealand, DMAA use as a party drug has been implicated in at least 1 hemorrhagic stroke. In America, DMAA is associated with a graded pictogram. A study in the French police database of crashes and in the national health care database showed an increased risk of being responsible for the crash, use of medicines and drugs, and other risk factors.

Our objective was to describe the factors associated with being responsible for a serious road crash and patient-reported use of labeled medications.

### Factors Associated With Serious Traffic Crashes: A Prospective Study in Southwest France

D rugs affecting driving ability (DADAs) directly or by indicating at-risk diseases are classified in a 4-level standardized classification associated with a graded pictogram. A study in the French police database of crashes and in the national health care database showed an increased risk of being responsible in drivers exposed to level 2 or level 3 drugs but did not include information on sleepiness, the use of illicit drugs, or other occupational factors.

Our objective was to describe the factors associated with being responsible for a serious road crash and patient-reported use of labeled medications.

### Methods
All adult drivers hospitalized at least 24 hours (ie, a serious crash) in Limoges, Bordeaux, or Toulouse, France, in 2007 through 2009 were queried using structured questionnaires about the circumstances of the crash, use of medicines and drugs, and other risk factors (eg, alcohol, sleepiness at the wheel, sleep apnea, or concomitant diseases). Blood alcohol content was abstracted from patient files. Police reports provided responsibility for the crash. Exposure to risk factors, including medication, was compared between responsible...