detect a difference in the time health care providers took to answer questions from APSO vs SOAP notes. Further studies are needed to determine whether these outpatient findings at one center can apply to another, or to inpatient or emergency department settings, or even to radiology and pathology reports. Readability of EHR notes will be increasingly important as more organizations adopt EHRs. This study demonstrates that a structural change in the health care provider EHR progress note, from SOAP to APSO format, is feasible and generally well received.

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Published Online: November 26, 2012. doi:10.1001
2013.jamainternmed.474

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Author Contributions: Study concept and design: Lin and Caplan. Acquisition of data: Lin and McKenzie. Analysis and interpretation of data: Lin, McKenzie, Pell, and Caplan. Drafting of the manuscript: Lin and Caplan. Critical revision of the manuscript for important intellectual content: Lin, McKenzie, Pell, and Caplan. Statistical analysis: Caplan. Obtained funding: Lin. Administrative, technical, and material support: McKenzie. Study supervision: Lin.

Conflict of Interest Disclosures: None reported.

Funding/Sponsor: Dr Caplan is supported by Career Development Award (07-221) from the Department of Veterans Affairs, Health Services Research & Development Service.

Disclaimer: The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs.

Methods. We used databases in the Medicines Monitoring Unit of our institution that included dispensed community prescriptions, hospital discharge data, regional laboratory data, and other data. The study population consisted of residents of Tayside, Scotland, who were registered with a primary care physician between 1993 and 2007 and remained resident in Tayside or died during the study period. Study subjects had at least 1 serum triglyceride measurement between 1993 and 2007, entered the study on the date of their highest triglyceride measurement during the study period, and were categorized by triglyceride concentration into 1 of the following 3 cohorts: 149 mg/dL or lower (group 1); 150 to 499 mg/dL (group 2); or 500 mg/dL or higher (group 3). (To convert triglycerides to millimoles per liter, multiply by 0.0113.) The primary study outcome was incident AP during follow-up (hospitalization with a primary diagnosis of AP or serum amylase activity of 300 U/L or higher during follow-up [reference interval, 0-100 U/L]). Data were summarized as mean (SD), or number of subjects (percentage).

A Cox regression model was constructed to adjust for potential confounders; data were expressed as hazard ratios (HRs) with 95% CIs. Covariates were age at study entry; sex; socioeconomic status; concentrations of total and high-density lipoprotein (HDL) cholesterol; comorbidities of gallstones, other biliary disease, diabetes, alcohol-related liver disease, alcoholic cirrhosis, alcoholic hepatitis,6 alcohol hospitalization, chronic pancreatitis, and renal failure; and use during follow-up of gastrointestinal drugs, diuretics, lipid-regulating drugs, analgesics, sodium valproate, antibiotic drugs, corticosteroids, estrogens and hormone therapy, and musculoskeletal and joint disease drugs. The Scottish Index of Multiple Deprivation7 was used as a measure of socioeconomic status. Population-attributable risks (PARs) were calculated for each triglyceride group and other AP risk factors. Sensitivity analyses were performed by (1) excluding subjects with hospitalization for gallstones, chronic pancreatitis, renal failure, alcohol morbidities, other biliary disease, and not adjusting for concentrations of

Acute Pancreatitis

Acute pancreatitis (AP) is common and potentially serious.1 Common causes are gallstones and alcohol abuse; other causes include medications, common bile duct obstruction, trauma, and hypertriglyceridemia.2 Although the association between hypertriglyceridemia and AP is well established, estimates of risk are based on case series and studies of high-risk groups.3,4 The risk of AP from hypertriglyceridemia in the general population is not well characterized. We report results from a cohort study using record-linkage methods to estimate the risk and relative burden of AP in patients with differing degrees of hypertriglyceridemia.
Results. There were 31,740 subjects in group 1, 31,887 in group 2, 36,422 in group 3. There were 116 AP events in group 1, 178 in group 2, and 37 in group 3 during the follow-up for categorization. Use of statins, antibacterial drugs, diuretics, or musculoskeletal joint drugs was associated with a lower hazard ratio for AP. Use of statins, antibacterial drugs, diuretics, or musculoskeletal joint drugs was associated with a lower hazard ratio for AP. Use of statins, antibacterial drugs, diuretics, or musculoskeletal joint drugs was associated with a lower hazard ratio for AP. Use of statins, antibacterial drugs, diuretics, or musculoskeletal joint drugs was associated with a lower hazard ratio for AP. Use of statins, antibacterial drugs, diuretics, or musculoskeletal joint drugs was associated with a lower hazard ratio for AP. Use of statins, antibacterial drugs, diuretics, or musculoskeletal joint drugs was associated with a lower hazard ratio for AP. 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adjustment for covariates and removal of patients hospitalized for gallstones, chronic pancreatitis, alcohol-related morbidities, renal failure, and other biliary disease). The HR for AP associated with severe hypertriglyceridemia (≥500 mg/dL) was higher than the HR associated with moderate hypertriglyceridemia (150-499 mg/dL). A much greater proportion of AP cases was exposed to moderate rather than severe hypertriglyceridemia, explaining why the PAR of AP attributable to moderate hypertriglyceridemia was 18.37% compared with 7.74%.

Comment. This study was population-based, with long follow-up (15 years) and low migration. We validated the 82% of cases where records were retrievable and confirmed the accuracy of diagnosis in 95.3%. We adjusted for an extensive range of confounders and performed a wide range of sensitivity analyses to test the robustness of the relationship between triglyceride concentration and incident AP. However, unmeasured confounders may have influenced the results. Nevertheless, observational studies are the only realistic approach to study this association given the low incidence of AP (about 1 per 1000 person-years of follow-up). Our findings that statins were associated with reduced risk of incident AP are consistent with the results of a recent meta-analysis of 28 randomized controlled trials of lipid-modifying drugs.8

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Accepted for Publication: August 6, 2012.
Published Online: November 26, 2012. doi:10.1001/jamainternmed.2012.477

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Conflict of Interest Disclosures: None reported.

Additional Information: All authors have completed the Unified Competing Interest form (available on request from the corresponding author).


Availability of DMAA Supplements Despite US Food and Drug Administration Action

The stimulant DMAA, also known as 1,3-dimethylamylamine, has been the subject of much controversy.1 In the United States, it is currently marketed as a dietary supplement, primarily in products promoted as a preworkout supplement for boosting strength, energy, and power. Two of the most prominent supplements containing DMAA are “Jack3d” and “OxyELITE Pro” (USP Labs) However, there are over 250 commercial dietary supplements containing DMAA on the market.2

As has been reported elsewhere,1 DMAA supplements are immensely popular among consumers. However, there is great concern among health professionals and regulators for several reasons. First, it is unlikely that DMAA is truly of natural origin. Therefore, its marketing as a dietary supplement may be illegitimate. Second, there are significant safety concerns. To date, there have been over 40 reports of serious adverse events, including at least 2 reports of death.2,3

On April 27, 2012, the US Food and Drug Administration (FDA) sent warning letters to 10 manufacturers of 16 products containing DMAA. The warning indicated that the products were considered adulterated because DMAA is considered a new dietary ingredient (NDI).3 NDIs require the manufacturer to submit some documentation demonstrating the expectation of safety. Without such documentation, the FDA considered the products to be adulterated, unapproved drugs.

It came to my attention on May 17, 2012, that some of these products were still available for sale through on-