Restless Leg Syndrome may indicate vein disease

By Gary Dworkin, MD

"Restless Legs Syndrome" is a poorly understood but common patient complaint.

In this disorder, patients experience intense, unpleasant sensations in their legs and an urge to move their legs in an effort to relieve these sensations. Moving the legs or exercising temporarily relieves the sensations that patients describe as "antsy," "wormy" and in 30 percent, painful. Women are affected more than men, and lying down and trying to relax usually triggers the sensations. Typically, the area between knee and ankle is involved. Obviously, Restless Legs Syndrome is a real sleep disrupter.

In the United States, more than half of the RLS patients are treated with several classes of neurologically directed medications with variable results and, of course, occasional side effects. However, the evidence in support of a purely neurological cause of Restless Legs Syndrome is still not compelling.

I wanted to share with you several recent and well done studies that reinforce not only the strong presence of documented chronic venous disease in patients with criteria established Restless Legs Syndrome (RLS), but also a surprisingly effective treatment for RLS when venous insufficiency is found in these patients.

The new information is that many, (perhaps nearly 50 percent) of RLS patients, have been found to have quantifiable and substantial chronic venous disease. Treating this venous insufficiency with the newer and effective minimally invasive techniques (Laser/EVLT), is now a reasonable and medically safe approach to the RLS patient.

The first medical study, (McDonagh, B., et. al., Vol.22, No. 4, PHLEBOLOGY, 2007) documents the surprisingly close association between patients who meet the International RLS Study Group criteria for RLS and are found to have ultrasound documented chronic venous disease.

> "There are a number of medical history similarities between RLS patients and those with symptomatic chronic venous disease. RLS may be a syndrome still in search of a cause, but there is evidence that there exists a disproportionate number of RLS patients who also have documented chronic venous disease."

The second study, (Hayes,C.A., et. al.,Vol.23, pg. 112-117, PHLEBOLOGY, 2008) takes this information and actually studies the effect of treating established RLS patients with laser endovenous ablation.

The results are quite good in eliminating or greatly diminishing RLS symptoms. Dr. McDonagh's and Dr. Hayes' research groups have been instrumental in developing both diagnostic and treatment recommendations for RLS. We owe these physicians a great deal of admiration and respect for continuing their efforts on behalf of patients with RLS.

The RLS patient is often difficult to diagnose, let alone treat. However, there are a number of medical history similarities between RLS patients and those with symptomatic chronic venous disease. RLS may be a syndrome still in search of a cause, but there is evidence that there exists a disproportionate number of RLS patients who also have documented chronic venous disease. It is becoming apparent that the two diseases are so intertwined, that the cause, perhaps of both, may be realized soon. The data that endovenous laser ablation of venous insufficiency in the RLS patient is effective in eliminating RLS symptoms is good news for our patients.

At Vein Specialists of Tampa, our treatment of RLS patients who have venous insufficiency has been quite successful. I am no longer a skeptic.

Finally, we can offer a treatment for the RLS patient that requires no chronic medication and is effective and safe. **VTN**

Dr. Gary H. Dworkin is a board-certified cardiovascular and thoracic surgeon; a diplomat of the American Board of Thoracic Surgery; a member of the Southern Thoracic Surgical Society and the Society of Thoracic Surgeons; president of the Florida Society of Thoracic and Cardiovascular Surgeons; and president-elect of the Cleveland Clinic Alumni Association. He has practiced cardiovascular and thoracic surgery for more than 18 years, but today, Dr. Dworkin dedicates his medical career to the treatment of venous disease at his Vein Specialists of Tampa (tampaveinspecialists.com).

MEANINGFUL USE

continued from page 18

go out of their way to help trouble-shoot and otherwise make the feature and overall system work.

It is clear that physician involvement and cooperation in the rollout, as well as use of the EMR, is essential to MU as well as overall EMR success.

Physician commitment requires at least training, a positive attitude and discipline (both self-discipline and holding others to a commitment to learn and use the EMR). However, an even more effective level comes if providers are involved with system planning and rollout (the earlier the better), and when they are prepared for and then see the value they can get from using system features.

Examples include seeing reduced miss-cues in the Pre-Determination process, Recommendations that are supported by EMR documentation, and safety alerts regarding allergies to latex, lidocaine, or other drugs.

4. Computer-based Provider Order Entry (CPOE)

The most important issue to recognize when addressing the CPOE part of MU is that Stage 1 only requires using CPOE for medication orders. For many phelebology practices, they may decide to NOT use e-prescribing.

Furthermore, the federal law on this says that orders may be ". . . directly entered by any licensed health care professional who can enter orders into the medical record per state, local and professional guidelines," which gives the EP sufficient latitude in delegating data entry for CPOE.

Standard orders and order sets associated with specific problems, recommendations, and visit types also can make it easier. However, the ultimate secret to successful CPOE is making sure every ordering physician gains an understanding of how CPOE works and how to use it, and enforcing its use.

5. E-prescribing — Either Do It As Often As Possible, or Not At All.

Different phlebology practices will handle this differently. If a practice routinely hands out a lot of prescriptions, then I recommend that they continue to do that, but just learn to do it with CPOE/e-prescribing.

Especially during the "First Year" of MU participation, physicians can exclude this requirement if they prescribe less than 100 prescriptions during the 90-day reporting period.

For the second year, physicians can opt out of this requirement only if they prescribe less than 100 prescriptions *during the entire year.*

My recommendation is to hold off on e-prescribing during the first month — just experiment with it once a week or so; then, as you gain familiarity with it, use it more during months two and three of the initial 90-day reporting period. Then, when you start your second year of MU, you will be completely comfortable with the functionality of this important feature.

Part of what is necessary to overcome the challenge is under the direct control of eligible professional practices: GET A FAVORITES LIST. If your EMR cannot allow you to create a favorites list and modify it easily on demand, then do NOT buy that EMR.

6. Develop a Process For Managing Clinical Decision Support (CDS).

One important nuance to keep in mind about the CDS requirement is that the CDS rules are *per provider.* This may appear to be simple, but it can be demanding, and I encourage every practice trying to achieve meaningful use to develop a robust process for designing and implementing CDS rules.

That process should include review and approval, documentation of specifications, development and testing, and finally formal release of each rule, including version documentation and control. This process puts practices in a position to get started with rules (and rule components) that can be shared among providers and specialties, and expand them both to qualify more providers and expand the kinds and number of rules used — as Stage 2, Stage 3 and possible further

MEANINGFUL USE
continued on page 26