# *Blanket orders*, an unadvisable practise, yet more and more frequent☆

## *Blanket orders*, práctica desaconsejada pero cada vez más frecuente

*Dear Editor,*

One concern in relation to drug safety is to reconcile the patient's treatment when changing to another healthcare area. There are reports showing that hospital admissions and transfers to different hospital services or hospital discharges are a cause of error in the treatment medication.

The process of conciliation of the treatment at discharge includes a double supervision. Both, the list of drugs that the patient was taking prior to admission and the drugs prescribed during admission must be conciled to obtain a single list. Generic orders or instructions, such as "resume usual medication", "continue the usual treatment" or "maintain the same treatment", known as *blanket orders*,[1,2] are not acceptable.

We have assessed the magnitude of *blanket orders* in our department, how it has been evolving and associated variables. To that effect, we performed a retrospective analysis of hospital discharges and outpatient reports issued at our hospital's Department of Nephrology from 2006 to 2014. The following variables were collected: date of the report, author, days of admission, age and gender of the patient, presence of multiple pathologies (4 or more diseases), renal replacement therapy (dialysis), use of and the type of *blanket order*. Our hospital does not have computerised medical records, clinical reports are the only tool available to clinicians to report therapeutic changes.

During the period of evaluation, 2358 clinical reports were issued at our department. After excluding deceased patients ($n = 61$), the number of reports analysed for this study dropped to 2297. Of these, 1190 were hospital discharges (50.5%). Fifty-five per cent (55%) of the patients were male, 68.3% had multiple pathologies and 26% were on dialysis. *Blanket orders* were used in 50.2% of the cases (1153), with a greater frequency in hospitalised patients than in outpatients (53.1% vs. 47.1%; $p = 0.004$). The types of *blanket order* found were: "continue the usual treatment" in 65% (751); "as indicated at the time of discharge" in 27.4% (316); "rest of medication as prescribed by another specialist" in 4.16% (48); and other *blanket orders* in 3.2% (37). The percentages of *blanket orders* increased over the years (37.5% in 2006 compared with 57.8% in 2014, $p = 0.0001$), but were not influenced by the month issued, nor by the patients' age or gender. On the contrary, *blanket orders* were more frequent in patients with multiple pathologies (55.3 vs. 38.1%, $p = 0.000$), in patients on dialysis (64.8 vs. 44.9%, $p = 0.000$) and in patients admitted for a short periods of time (mean ± SD) ($6.98 \pm 6.29$ vs. $10.25 \pm 8.23$ days; $p = 0.0001$).

*Blanket orders* are used in almost half of the clinical reports and the data indicate that, far from diminishing, this practice is progressively more frequent. It is not surprising that *blanket orders* are more common in patients with brief hospital stays and multiple pathologies, in whom therapeutic conciliation is more complex and requires greater effort. Although medical records are not computerised, we do have a follow-up programme for patients on dialysis, which would explain the existence of a high percentage of *blanket orders* in these patients (possibly by giving them a copy of the software without transcribing such treatment in the discharge report).

The use of *blanket orders* is a practice that should be eliminated. In fact, they are explicitly prohibited by the JCAHO's Medication Management Standard MM 3.20.[3] The existence of this type of order immediately shows that the conciliation of treatment was not done. In 2006, the JCAHO added the requirement of giving to patients the reconciled medication list at discharge, written in appropriate and understandable language.[4]

We hope that in the future new computer tools will help to improve this type of care; however, awareness of this issue by all professionals will continue to be essential.

### Conflicts of interest

The authors declare that there are no conflicts of interest.

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# Gaucher disease and Lupus: A rare association?

## Gaucher y lupus: ¿una rara asociación?

*Dear Editor,*

Gaucher disease (GD), is an autosomal recessive lysosomal storage disease that is due to mutations in the glucocerebrosidase (GC) gene, with a prevalence of 1/57,000 to 1/75,000 births worldwide[1] and significantly more common among the Ashkenazi Jewish heritage.[2] GD is categorized into three clinical types[4] and the clinical manifestations result from the accumulation of the lipid-laden macrophages in the spleen, liver, bone, bone marrow,[3] leading to impairment of central nervous system in the most severe cases.[4]

Although several reports are available related to the risk of GD patients developing other diseases like Parkinson's disease[5] and increased rates of malignancies, particularly hematologic,[6] systemic lupus erythematous (SLE) has not been described in association with GD.

We report a case of a 32-year-old Caucasian woman diagnosed with GD type 1 at 17 years-old. She had a grandmother with GD, an uncle with SLE and a cousin with rheumatoid arthritis. There is no known Jewish heritage in her family. She was medicated with velaglucerase.

With 30 years old, the patient developed malar-rash and chest eczema, associated with sun exposure. One year after she noticed worsening asthenia, anorexia, nausea, hair loss, myalgias, bilateral gonalgia, oral ulcers, Raynaud syndrome and arterial hypertension (TA 140/90 mmHg). The patient was referred to the nephrology unit with peripheral edema and the laboratory investigation showed parameters of ferropenic anemia (without signs of hemolysis), leukopenia, thrombocytopenia, elevated seric creatinine, hypoalbuminemia, active urinary sediment and nephrotic-range proteinuria observed in the 24 h urine sample (Table 1). The immune assays revealed positive antinuclear antibodies (ANA) and anti-Sjögren's-syndrome-related antigen A, elevated immunoglobulin (Ig) G (20.7 g/L) and IgA (4.64 g/L), circulating immunocomplexes (>100 μg Eq/mL) and low serum complement (C3 0.16 g/L, C4 0.021 g/L, C1q 0.208 g/L). The complementary immunologic and serologic study was negative. Renal and abdominal ultrasounds showed normal sized kidneys, increased cortical echogenicity with maintained differentiation and mild/moderate homogeneous hepatosplenomegaly. Echocardiogram revealed thickened pericardium and nuclear magnetic resonance of the inferior members showed bone alterations and moderate intra-articular left knee and mild right knee effusion.

Kidney biopsy established the diagnosis of class IV-G lupus nephritis (LN) and the treatment according to KDIGO (Kidney Disease: Improving Global Outcomes) guideline[7] was started. Hydroxychloroquine was redrawn due to gastric intolerance. She was discharged 1 month after admission with serum creatinine 1.5 mg/dL, proteinuria 4500 mg observed in the 24 h

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