



difficult, and health care workers have to rely on a knowledge of HIV prevalence in the patient population. Factors that should prompt consideration of therapy in these difficult cases include a patient population with a high prevalence of HIV infection — patients seen at an inner-city emergency department, for example — or a massive percutaneous exposure to a large volume of blood.

David M. Patrick, MD

Associate Director
Division of STD/AIDS Control
BC Centre for Disease Control
British Columbia Ministry of Health
Vancouver, BC

Childproof caps open Pandora's box

Dr. Lynette Sutherland's letter "Childproof caps, revisited" (*Can Med Assoc J* 1996;155:1550) is written from the perspective of "a little old lady with arthritis and high blood pressure" and not from that of a physician. The Canadian Association of Poison Control Centres is concerned that her letter could be cited in reference to child-resistant closures (CRCs) for drug containers.

It is important to emphasize that CRCs save lives. Evaluations of the impact of CRCs have shown a 40% to 55% decrease in the ingestion of various products containing acetylsalicylic acid by children¹ and a 42% decrease in the ingestion of many drugs and consumer products.² Data published a few months ago show a 45% decrease in the mortality rate among children due to poisoning as a result of CRCs.³ At Winnipeg Children's Hospital, we had 32 admissions for poisoning with caustic alkali drain cleaners during the 7 years before mandatory CRCs and only 2 during the 7 years after implementation of that regulation. And, although this was not the intention,

CRCs also seem to have decreased the severity of intentional drug overdose in adults.⁴

CRCs have been described as "a success and a model for accident prevention."⁵ A particular strength of CRCs is that "the package is the message and serves as a constant reminder of safety education in the market place as well as in the home."⁶ There also seems to be strong public approval for this type of packaging.⁶

The association recognizes and acknowledges that CRCs present an obstacle to some senior adults.^{7,8} Sutherland and her physician can request that her pharmacist dispense her prescriptions in conventional containers. However, this approach must be carefully considered if young children visit her home. Studies show that 13% to 17% of all poisonings involving children less than 6 years old occurred away from their homes, with the most common site being grandparents' homes.^{8,9} However, a better solution is the development of CRCs that are easier to use for seniors, a step that our association supports.

The CMA agrees with the need for child-resistant packaging for hazardous drugs,¹⁰ which has been a remarkably successful injury-prevention intervention.

Milton Tenenbein, MD

President
Canadian Association of Poison Control Centres
Winnipeg, Man.

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[The author responds:]

I appreciate the interest that the Canadian Association of Poison Control Centres has taken in my problems with childproof caps. Although I wrote my letter with tongue in cheek, there is a serious issue here that I believe deserves debate and research.

Although the association believes that its activities have resulted in a victory in the battle for the safekeeping of children without there being a loser, I do not know whether that assumption is correct. Have we transferred a problem from one vulnerable social group to another? In our zeal to protect children, have we inflicted the cost of that protection on elderly people? Has anyone studied scientifically or economically the cost to seniors of the comprehensive use of childproof caps in the drug industry?

Do we know how many elderly people have suffered discomfort, disease exacerbation or even death simply because they were unable to open a bottle? Is society in a net "win" position as a result of the use of CRCs?

Prescription drugs are routinely dispensed with CRCs, and most adults are unaware that they have a choice. "Muddled" seniors are the last people who would be aware of such a choice. There is a good chance they may not think to raise the issue with their physicians or pharmacists and, if someone else is monitoring their affairs, they may suffer silently for years.



Most over-the-counter drugs have CRCs. There is often no choice in packaging.

CRCs are not just a problem for seniors. We have a large population of semiliterate as well as non-English-speaking people. For many of them, CRCs remain a mystery.

I wonder whether the association is claiming credit where credit is not due. Simply because there has been a reduced incidence of accidental poisoning in children coincident with the introduction of CRCs does not necessarily mean there is a causal connection. Is it possible that the reduction is the result of a better educated population?

Lynette E. Sutherland, MD, PhD
North York, Ont.

Calcium supplementation for the nation

The timing of the symposium on the prevention and management of osteoporosis (*Can Med Assoc J* 1996;155:921-65) was appropriate because of the immense magnitude of this problem in Canada.

One of the articles, "Calcium nutrition and osteoporosis" (*Can Med Assoc J* 1996;155:935-9), by Dr. Timothy M. Murray, drew attention to the need for calcium supplementation.

It seems ironic that the simple supplementation of ordinary orange juice with tricalcium citrate is not available to the Canadian public. For at least the past 10 years this calcium-supplemented orange juice has been available throughout the US. In that country, a glass of orange juice supplies as much calcium as a glass of milk. Calcium-supplemented orange juice is available at the same price as regular juice. The containers are specially marked with blue print and the screwtop on the container is also blue.

This calcium-fortified juice is available from every major producer of orange juice in the US. The same brands are available in Canada, but without the option of calcium supplementation. I wonder why Canadians nation wide are denied access to this product.

Walter P. Bobechko
Dallas, Tex.

[The author responds:]

Dr. Bobechko raises an important point. Supplementation of food products such as orange juice is an important source of calcium, particularly for those who cannot or will not consume dairy products. Such products can be supplemented at a level higher than the calcium level in vegetable sources. We have been aware of the availability of calcium-supplemented orange juice in the US for some time, and we would like to see such products available in Canada. Indeed, the Osteoporosis Society of Canada has endeavoured to help make such products available in Canada, in keeping with its view that informed and educated consumers should be able to obtain dietary calcium from a variety of food choices. The society has advocated the introduction of such products to the Canadian market by consulting with corporate partners in the food and beverage industry and with the Health Protection Branch of Health Canada. However, the issue is a complicated one that still awaits regulatory approval. Topics that need to be addressed include upper safety limits for calcium intake in the general population, whether health claims can be made for such products with regard to osteoporosis, the scope of the population at risk for osteoporosis, which products should be supplemented and the benefits of harmonization with US policies. We would like to see more consumer choice

and greater calcium availability through a wider variety of food sources.

Tim Murray, MD
Professor of Medicine
Metabolic Bone Clinic
St. Michael's Hospital
Toronto, Ont.

Checking random assignment with claims data

Dr. Norman F. Boyd ("The review of randomization in the Canadian National Breast Screening Study: Is the debate over?," *Can Med Assoc J* 1997;156:207-9) refers to our analysis of health insurance data on the Manitoba women enrolled in the National Breast Screening Study (NBSS).¹ One of the objectives of our study, which was funded by the National Cancer Institute of Canada, was to determine whether there was independent evidence supporting criticism of the random assignment procedures used in the NBSS. In Manitoba, we could construct a medical history for each woman before her entry into the trial with the use of a database generated as part of that province's health insurance system. The database includes claims data from the billing cards sent to Manitoba Health by fee-for-service physicians. Each card must include the reason for the visit (diagnosis) for the claim to be accepted and the physician paid.

The NBSS provided identifying information for each of the 9477 women who attended the screening centre in Manitoba, which we then linked with each woman's claims data. We retrieved all procedures and diagnoses related to the breast in the 24 months before each woman's entry into the NBSS. As Boyd notes, we identified 9 women who had a claim for breast cancer