venous bolus of insulin at the initiation of insulin therapy.

Many children present to emergency departments staffed by physicians who have a wealth of experience in the management of adult patients with diabetic ketoacidosis but who may not be familiar with the different management considerations required for children and adolescents with this condition. We feel it is important to increase awareness of the more conservative fluid management recommended for pediatric patients, in the hope that this may decrease the incidence of cerebral edema and improve outcomes.

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[One of the authors responds:]

Sarah Lawrence and colleagues are correct: our paper addresses hyperglycemic decompensation in adults only. This was clearly stated in the introduction in an early version of the manuscript, but the information was inadvertently omitted from the final, shortened version. However, the target age group is mentioned in the caption for Fig. 2 of our article.

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Opt out, not opt in

According to a document recently published by the US Centers for Disease Control and Prevention,[1] the province of Ontario, which uses an opt-in approach to prenatal screening for HIV infection, had an abysmal testing rate of only 54%. Such a low rate is clearly unacceptable. Critics of the opt-out strategy argue that it eliminates a woman's autonomy and that it is unethical to perform such an important test without true informed consent. However, given that antiretroviral therapy in HIV-positive pregnant women can potentially reduce vertical transmission rates from about 25% to less than 2%, as reported by Sharon Walmsley in her recent commentary,[2] is there really any argument for continuing to offer testing on an opt-in basis?

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The drivers of self-discharge

Richard Saitz suggests that intravenous drug use, dates of distribution of welfare cheques and other factors may be reasons for patients wanting to be discharged from hospital against doctors' orders.[1]

But has Saitz ever been a patient on an acute care surgical ward? I was admitted to hospital for removal of my gallbladder, which led to an 8-day stay because full open surgery and insertion of a Jackson-Pratt drain were required. Besides the abominable food and resultant hunger and acid reflux, the constant noise (beeping IV pumps and ringing telephones) prevented sleep, day or night. The nurses were fantastic but should have been issued roller skates. Around 4 am there was generally a lull and I was able to doze off, only to be awakened by someone pushing the door open to see if I was OK. Getting back to sleep was almost impossible. Add to all this the patient down the hall who was smoking in his room (I am allergic to smoke), and you can understand why I announced on day 8 that if the doctor did not sign my discharge, I intended to discharge myself.

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[The author responds:]

Anne Sutton Brown's experience does not invalidate the systematic observations made in methodologically rigorous studies such as that by Anis and associates[1] or in other work that I cited in drawing my conclusions.[2] Nonetheless, these studies are clearly not representative of all experiences. For example, the experiences of HIV-positive patients in Vancouver may not apply to patients undergoing gallbladder surgery in Montréal, and vice versa.

As I stated in my editorial,[2] "the most important void in the literature on discharges against medical advice is the