

were surprised by the low use of ACE inhibitors or equivalent for patients who had diabetes but no clinical evidence of CAD.

These preliminary results indicate that there is room for improvement in implementing treatment guidelines in clinical practice. The overall use of cardioprotective medications was suboptimal at the initial visit, although use had increased significantly by the time of the most recent visit (Table 1). However, the use of ACE inhibitors remained suboptimal among diabetic patients without CAD, a result similar to the data presented by Brown and associates.¹ We agree that multidisciplinary cardiovascular risk reduction programs are needed to improve quality of care in high-risk patients.

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***C. difficile*: Will lessons be learned?**

Laura Eggertson¹ reports that “there were 7004 cases of [*Clostridium difficile*] across Quebec from Apr. 1, 2003, to Mar. 31, 2004, and 1270 people died.” Additional data in her article reveal a staggering increase in both morbidity and mortality due to *C. difficile* from 2001 to 2003,¹ yet the provincial government only recently intervened with policies to aggressively control the outbreak. Moreover, some health care

professionals have reported a lack of sufficient resources to effectively control the outbreak.² This state of affairs raises 2 issues: first, how health care institutions effectively intervene when a pathogen manifests in a community and, second, the allocation of resources to achieve desired social goals.

The fact that, until recently, reporting of hospital-acquired infections to health care authorities was not required points to both structural and procedural shortcomings within our health care institutions. The recent establishment of province-wide surveillance and infection-control committees is intended to rectify the structural deficiencies, although the effectiveness of these measures remains unknown. In addition, procedural interventions appear to have been underused, both clinically and interpersonally. Clinically, health care professionals should have been informed by a provincial nosocomial infection control committee about the technical means of controlling the outbreak. This advice should have been based on the best evidence available and should have been provided as soon as possible after the increase in incidence was noted.³⁻⁵ At an interpersonal level, patients or their representatives should have been informed of the increased risks and patient groups should have been engaged in consultation and decision-making.

Yet these structural and procedural interventions cannot be undertaken without the addition of the resources needed for their implementation. If hospitals have to redirect existing scarce resources from other services to combat *C. difficile*, overall quality of care could decline.

But the saddest lesson from the *C.*

difficile outbreak has been exposure of the lack of planning and coordination in the face of a virulent form of a known infection. I hope the lessons of the *C. difficile* epidemic serve as a grave warning in case of future outbreaks of new pathogens.

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Influenza vaccine for all?

I find it interesting that, a few weeks after celebrating the achievements of the Cochrane Collaboration,¹ *CMAJ* published a systematic review² and a recommendation statement from the