ing a benefit over placebo is analogous to not treating meningitis in pregnancy because there are no randomized trials to demonstrate that penicillin is better than placebo in pregnancy.

Zitner and Bischoff quote one of us as having said, elsewhere, that "What we found was that [among] pregnant women who use Paxil through pregnancy until birth, their offspring are more likely to have several stormy weeks at infancy." This was taken out of context, as they omitted the accompanying statement that "Many of these babies have to stay in the hospital for two to three weeks after they're born, but they suffer no long-term health effects."⁵

Although it may be possible for some women to avoid taking antidepressants as Zitner and Bischoff suggest, they do not offer an alternative approach for the substantial number of women who have major depressive symptoms during pregnancy. Antidepressants continue to be prescribed and it is important that pregnant women and their health care providers have accurate information upon which to base an informed decision regarding therapy.

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A positive prognosis

We read with interest the recent report by Krishna Sharma¹ of a case of malignant fibrous histiocytoma, metastatic to the lung, with spontaneous expectoration of large tumour fragments. We felt it would be illustrative to present a similar case with a much more favourable outcome.

This patient presented in 1975 at the age of 42 years with a slowly enlarging mass, involving the right patellar tendon. A biopsy revealed it to be a malignant sarcoma, and a subsequent wide local excision was accomplished with clear margins. Pathology review confirmed the diagnosis of malignant fibrous histiocytoma. No adjuvant treatment was administered.

Five years after primary resection, the patient developed pulmonary nodules, one adjacent to each hilum, visible on both routine posteroanterior chest radiographs and lung tomograms. He was asymptomatic, and no further treatment was recommended. Over the next 8 months, he developed mild but progressive wheezing. This culminated in the spontaneous expectoration of a tumour nodule described as a plug of tissue measuring 2.5 × 1 cm and found to be histologically identical to his primary cancer. The wheezing completely resolved at this point but because of the enlargement of his remaining disease site, with the largest nodule measuring 5 cm in diameter, a course of radiation therapy was recommended. He received 30 Gy in 15 fractions, encompassing both hila and the carina, using cobalt 60. This was well tolerated aside from transient fatigue. The patient's tumour masses began to shrink promptly, and he was eventually left with a small amount of residual scarring near his left hilum.

When last seen in follow-up in 2003, some 22 years after the spontaneous expectoration of one of his lung nodules and subsequent "palliative" radiation treatment of his residual disease, the patient remained alive and well, without disease recurrence.

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Predicting cardiac outcomes

Despite substantial advances in the diagnosis of suspected acute coronary syndromes, significant challenges persist.¹ Andrew Worster and colleagues recently reported in *CMAJ* that ischemia-modified albumin (IMA) was a poor predictor of cardiac outcomes in patients with potential cardiac ischemia symptoms.² The authors tested 2 thresholds for IMA: 85 µ/mL, as suggested by the manufacturer, and 80 µ/mL. It is important to point out, however, that IMA levels vary considerably, even among healthy individuals. Taking these variations into account may improve the predictive characteristics of IMA.

We examined 35 healthy men (age range 25–54 years) recruited from the general public who had not had a myocardial infarction. Using standard laboratory techniques we found that the average resting IMA concentration was 94 µ/mL (97.5% confidence interval 84–104 µ/mL). IMA concentration was significantly and inversely correlated with serum albumin but not with creatinine concentration. Serum IMA concentration was also significantly associated with serum lactate concentration.³ Taking these and other known factors into

account may improve the utility of IMA in predicting serious cardiac outcomes.

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We thank Giuseppe Lippi and colleagues for their comments. The average serum level of IMA that they reported in their study (94 µ/mL, 97.5% confidence interval 84-104 µ/mL) is higher than the 2 cutoffs we employed: 85 µ/mL (suggested by the manufacturer) and 80 µ/mL. In our paper we indicated that we explored multiple IMA thresholds (including 100 µ/mL) but this did not alter our findings.¹ Therefore, in patients presenting with chest pain who have not yet experienced a serious cardiac outcome, IMA appears to be a poor predictor of serious cardiac outcomes.

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Questioning the benefits of statins

The assessment by Douglas Manuel and associates¹ of the 2003 Canadian dyslipidemia guidelines² is welcome, but they overlooked the all-cause mortality issue, where statins have essentially failed to deliver.¹ There are no statin trials with even the slightest hint of a mortality benefit in women,³⁻⁵ and women should be told so. Likewise, evidence in patients over 70 years old shows no mortality benefit of statin therapy: in the PROSPER trial there were 28 fewer deaths from coronary artery disease in patients who received pravastatin versus placebo, offset by 24 more cancer deaths.⁶

The failure of statins to decrease all-cause mortality is possibly best illustrated by atorvastatin: while both the ASCOT⁷ and TNT⁸ trials found that atorvastatin therapy decreased the risk of cardiovascular events, in the ASCOT trial (placebo v. 10 mg atorvastatin daily) the all-cause mortality curves effectively touched at mean study end (3.3 years) and in the TNT trial (10 v. 80 mg of atorvastatin daily) there were 26 fewer deaths from coronary artery disease in patients taking the higher dose offset by 31 more noncardiovascular deaths at median study end (4.9 years). Incidentally, the ASCOT trial failed to find a cardiac benefit of statin therapy in women and patients with diabetes.

The Web site of the ALLHAT study says it best:⁹ "trials [primarily in middle-aged men] demonstrating a reduction in [coronary artery disease] from cholesterol lowering have not demonstrated a net reduction in all-cause mortality." What is the point of decreasing the number of "events" without decreasing overall mortality, when the harm caused by the side effects of statin therapy is factored in?

The failure of statins to reduce all-cause mortality clearly supports the call for more effective approaches. Guidelines should reflect this finding, certainly in their recommendations for women and probably in those for most men too.

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The recently published controversy on the 2003 Canadian dyslipidemia guidelines¹⁻³ should be cause for some reflection on the utility of guidelines. The back-and-forth dialogue was reminis-