Osler–Weber–Rendu syndrome

The attached image (Fig. 1) is intended to complement the pulmonary radiography and CT imaging that accompany the report of a case of hereditary hemorrhagic telangiectasia described by Narinder Pal Singh and colleagues.[1]

It is this observer's experience that telangiectasia have a predilection for the skin of the face and tend to intensify with advancing years. Anatomically, the signature mucocutaneous vascular lesions consist of dilatations of the capillaries and venules that, importantly, blanch on pressure. Red to purplish, they are usually pinpoint sized but may be frankly nodular, as depicted (Fig. 1).

Hence, these dermal markers alert physicians to the possibility of concomitant visceral arteriovenous fistulae, which interestingly can also involve the myocardium,[2] mimicking coronary heart disease.

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DOI:10.1503/cmaj.1060182

Not safer and not cheaper?

Roberto Palencia and associates,[1] in their analysis of the economic outcomes of the Term Breech Trial, report that planned cesarean birth is both safer and cheaper for breech fetuses than planned vaginal birth. However, the authors have analyzed only their early results, in which newborn outcomes favoured planned cesarean birth.[2] They have not referred to their own results at 2-year follow-up, which showed no difference in outcome for the babies or the mothers,[3,4] thus demonstrating the resilience of both the newborns and of the mothers' pelvic floor. In addition, in their economic analysis, Palencia and associates looked only at immediate costs, thus vastly underestimating the real costs of elective cesarean for breech or any birth. Since most women will have more than one birth, the presence of a uterine scar will expose women to increases in placenta previa and placenta acreta,[5] ectopic pregnancy,[6] abruption,[5] infertility,[7] stillbirth[8] and excess hospital readmissions because of the cesarean[9] and adhesion-related intestinal obstruction.[10] All of these costs have been ignored.

This analysis led to headlines in the popular press that cesarean births are both safer and cheaper. This lack of nuance fuels societal views that increasingly suggest that cesarean section is just another way of giving birth; in addition, it undermines the confidence of a generation of women who are coming to believe that they cannot give birth without massive technological assistance.

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Fig. 1: Facial telangiectasia.

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DOI:10.1503/cmaj.1060106

[Three of the authors respond:]

Michael Klein argues against our conclusion[1] that planned cesarean section was safer and less expensive than planned vaginal birth during the period reported in the Term Breech Trial. He bases his arguments on other studies by us,[2,3] which "showed no difference in outcome for the babies or the mothers" at 2-year follow-up. He also claims that by looking only at the duration of the Term Breech Trial we have "vastly underestimate[d] the real costs of elective cesarean for breech or any birth." While we agree that a longer-term analysis might be useful, we disagree with these arguments.

The argument that our own studies show no difference at 2 years represents a misunderstanding of the results of those trials.[2,3] The appropriate interpretation of those results is that the benefits of planned cesarean section are limited to reducing perinatal and neonatal mortality and serious neonatal morbidity during the first 6 weeks of life. These remain important benefits for the baby, the mother, the family and the health care providers.

Regarding the question of what will happen to the costs of planned cesarean section and planned vaginal birth after, say, 2 years, the answer is "we do not know." Any argument that the costs will be higher is nothing more than speculation. For example, we agree with the assumption that most women will have more than one birth, but we do not know if breech presentation will occur for the first birth, the last birth or a birth in between. Also, our experience from the Term Breech Trial has taught us that until actual resource utilization is measured in a controlled environment, it is not easy to predict what will happen. We thought that planned cesarean section would be more expensive than planned vaginal birth, but found that it was not. Furthermore, there was no single specific factor that explained why the costs of planned cesarean section were lower, which tells us that it is dangerous to try to predict (rather than measure) future costs.

Finally, we do not feel responsible for the headlines and content of what is published in the popular press. The Interpretation section of our paper discusses the study's limitations and the consequent constraints on any conclusions drawn.

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DOI:10.1503/cmaj.1060146

Multitherapy for diabetes

Julie Ménard and associates[1] used pravastatin or bezafibrate (or both) as a component of intensive multitherapy in their study of patients with type 2 diabetes mellitus. Although pravastatin is of questionable benefit (according to the ALLHAT-LLT study,[2] in which no cardiovascular, peripheral vascular, cerebrovascular or mortality benefits were found), my main concern here is with the use of fibrates.

Fibrates, including bezafibrate, are effective in lowering low-density lipoprotein cholesterol and triglycerides while raising high-density lipoprotein cholesterol, but there was no mortality benefit in a large bezafibrate trial.[3] In addition, there have now been 3 trials with different fibrates (gemfibrozil,[4] clofibrate[5] and fenofibrate[6]) that ended with numerically more deaths in the group receiving fibrates than in the placebo group.

Fibrates lull patients and doctors into a false sense of accomplishment by bringing several blood lipid markers closer to guideline targets, thus reducing the urgency of more difficult dietary and lifestyle changes. However, with "over two-thirds of patients with diabetes [dying] of cardiovascular causes,"[7] the established failure of fibrates to lower mortality should lead to an urgent call to stop their use and to examine the clinical efficacy of the lipid guidelines.

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