The “battle” against cancer

Downar is to be praised for his brave call to abandon the outmoded language of warfare in the “battle” against cancer.¹ Our job is to help people with cancer survive their illness as well as possible for as long as possible. We do them a terrible disservice by suggesting that their individual strength of character and ability to endure suffering will pull them through. To do so ignores all the evidence about both low and high mortality rates for various cancers despite maximal therapy and patient commitment to be cured. So much of the influence on survival either predates diagnosis or depends on early diagnosis and treatment for so many cancers. We must avoid the risk of adding insult to injury by mindlessly blaming the patient for lack of response to treatment. As a lucky survivor of colon cancer, I credit the expertise of my physician and surgeon for my survival rather than my own “inner strength.”

Paul J. Byrne MD

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DOI: 10.1503/cmaj.110-2128

Steroids in infection: an old wives’ tale

In their otherwise informative vignette about a 48-year-old woman presenting with headache, red eyes, blurred vision and hearing loss, Chan and colleagues perpetuate a common medical myth.¹ They caution that, “systemic steroids should not be administered before an underlying infection, which could be the cause of this clinical presentation, has been excluded.”

Unfortunately, there is a dearth of evidence supporting this claim, and at least one good study, which reaches the opposite conclusion. McGee and Hirschmann reviewed published randomized double-blind trials of steroids in infection and concluded that steroids are beneficial and safe for a wide variety of infections.² They noted that, for bacterial meningitis, steroids likely improve outcomes. Steroids were associated with worse outcomes for only two types of infections: viral hepatitis and cerebral malaria.

Dogged adherence to the old wives’ tale about steroids and infection continues to create the potential to delay safe and effective treatment.

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2. McGee S, Hirschmann J. Use of corticosteroids in treating infectious diseases. *Arch Intern Med* 2008; 168:1034-46.

DOI: 10.1503/cmaj.111-2003

We thank Prasad for his comments and agree that there is some evidence for clinical benefit of steroids in terms of survival, functional deficit and symptoms.¹ Our comment that steroids should be withheld before excluding an underlying infection in patients with meningitis may be misleading in suggesting that steroids are not useful for bacterial and tuberculous meningitis, because there is some evidence of benefit in these conditions.¹ The evidence needs to be re-examined. We also need to individualize treatment.

The conclusion by McGee and Hirschmann that steroids are beneficial and safe for a wide variety of infections¹ should not be taken at face value. There are infections (e.g., bacterial meningitis, severe typhoid fever and

tetanus) for which the clinical benefit of steroid treatment has not been convincingly shown for all patients. Although some investigators have seen improved outcomes for bacterial meningitis,^{2,3} others have found no benefit.^{4,5} Furthermore, the observed clinical benefit of steroids for typhoid fever and tetanus was found in studies that involved only patients with more severe disease.^{6,7}

The application of evidence-based recommendations on treatment should be appropriate to the specific clinical context. The studies of bacterial meningitis included only patients who had supporting evidence of bacterial infection (i.e., cloudy cerebrospinal fluid, bacteria seen on gram stain or white blood cell count $> 1000 \times 10^9/L$).^{4,6} Our patient was a 48-year-old woman with meningitis of unknown cause, and clinical assessment of cerebrospinal fluid suggested that the cause was nonbacterial. Furthermore, a risk–benefit analysis suggests that withholding treatment is preferred so as not to aggravate unidentified infections (e.g., fungal) with steroid treatment.

We subsequently diagnosed Vogt–Koyanagi–Harada disease. Retrospectively, we find little justification for empirical steroid treatment, given that this disease is not known to cause death or neurologic disability.

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Improving hospital food

I congratulate Kidd for bringing forward a valuable discussion on improving hospital food.¹ The entire health care system would benefit if hospitals and other health care institutions provided food that was better able to meet the nutritional needs of those consuming it, staff and patients alike.

However, I am concerned that Kidd uncritically quotes Matt Prentice, the chef responsible for starting a movement to improve hospital food, as follows: "Almost all the fruits and vegetables we use are organic, so yes, that was an increased cost." Since organic produce is more expensive than regular produce, and there is no evidence that it is any more nutritional, I hope that health care institution food services do not decide to waste precious funds purchasing organic produce. There are many evidence-based, cost-effective ways to improve the nutritional value of food, but buying organic produce is not one of them.

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DOI: 10.1503/cmaj.110-2129

Transparency makes for good quality health care

Having free and secure access to one's medical records is an important step in improving the quality of both primary

and specialty medical care. I am a specialist in developmental pediatrics, and for several years, it has been my practice to send a copy of my report to the patient's legal guardian. As indicated in Vogel's article,¹ giving a patient or parent the opportunity to read what has been written improves communication, encourages patient and family participation, and serves as a method of quality control. On several occasions, proofreading by a parent has resulted in my amending a report, thereby reinforcing the importance of providing accurate information. Medico-legal vulnerability may also be decreased when the medical report has been reviewed and accepted by the patient or family.

Transparency makes for good quality health care.

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DOI: 10.1503/cmaj.111-2005

Planning for final exit

CMAJ recently covered a seminar in Toronto at which Dr. Philip Nitschke discussed the right of people of sound mind to decide to end their lives and their right to a safe means to do so.¹ Readers may have the erroneous impression that the event was sponsored by the First Unitarian Congregation of Toronto.

In fact, the seminar was sponsored by Safe Exit International. Having been denied rentals at other public places in Toronto, the group approached us. We agree that people should be able to choose the time of their own death, and the Canadian Unitarian Council advocates for changes to the law about choice in dying. Safe Exit International, while supporting this concept, also advocates for obtaining illegal drugs or other means of committing suicide. Our position gives equal weight to the

need for better palliative care and community support so that terminally ill people receive what they need while they make their choices about death and dying.

Our position is consistent with Unitarian Universalists' core beliefs in the right of conscience and the use of the democratic process within our congregations and society, and that each person has the right to a free and responsible search for truth and meaning.

Ellen Campbell
President, Board of Trustees
Shawn Newton MDiv
First Unitarian Congregation of Toronto,
Toronto, Ont.

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Codeine v. morphine

Thank you for identifying the risks associated with codeine's wide use in Canada as a perceived safe and effective analgesic.¹ As a family physician, I respectfully suggest that the use of morphine instead of codeine for pain relief in children might lead to another serious side effect: unrelieved pediatric pain. Given the lack of education on chronic pain in most Canadian undergraduate medical curricula as well as recent concerns about overuse of opiates leading to addiction and diversion,^{2,3} I suspect that many nonspecialist physicians will be loathe to use morphine when needed. Parents may also raise concerns about using what they perceive to be a very potent opiate for their children.

Tramadol, which has been shown to be safe and effective in children,⁴ may be more acceptable for moderate non-cancer pain, provided that drug plans cover it. Our pediatrician colleagues can support those of us in primary care by commenting on the safety and efficacy of this drug, which has been widely used for decades in other countries. In the meantime, if we rashly discard codeine, let's be sure we have a