to treat symptomatic patients, cancer has been ruled out, and there are no significant contraindications, all studies have shown that α-blocking agents have a significant effect on all prostates, whereas finasteride has a beneficial effect only in men with significantly large prostates and major obstructive symptoms.

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Reference

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[One of the authors responds:]

The trial involving veterans, published while our article was in press, concluded that terazosin was significantly more effective than placebo, whereas finasteride was not. However, it turned out that the patients enrolled in this study had a mean prostate size identical to that in a normal population of men.[2] A meta-analysis (incorporating the results of our Canadian study) subsequently confirmed that only patients with enlarged prostates had a response significantly better than those taking a placebo.[3] It is obvious now, but not when we designed our study in 1991, that a drug whose action is to shrink the prostate only works in men with large prostates. Many of us, including Dr. Barkin, are concerned about the unacceptable failure rate of drug therapy, particularly after several years. In a long-term study of terazosin,[4] twice as many patients with small prostates (32%) as with larger prostates (16%) were still available for study after 4 years. By contrast, more than 90% of patients taking finasteride who entered open-label trials (and who presumably had a favourable response secondary to shrinkage and stabilization of their prostates) were still taking the drug and were available for study 5 years later.[5] These new and important findings allow busy clinicians such as Barkin a less confusing and more efficient, durable and evidence-based approach to the treatment of his patients who do not choose watchful waiting, who have an indication for drug therapy or who are reluctant to undergo surgery. Most men with symptoms but with normal-size prostates (50% or more of Barkin's patients) can be expected to have a favourable and durable response to α-blocking agents. Both α-blocking agents and finasteride can achieve similar results in men with larger prostates. With finasteride, we can expect the response to be durable over the long term.

Barkin was also concerned about the confusing finding of the study involving veterans that the PSA level decreased in the terazosin group, but not in the finasteride group.[1] In fact, the result was precisely the opposite. This error had passed through proofreaders, editors and multiple authors. One must question everything one reads. Even the *New England Journal of Medicine* can make a mistake.

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Wiping out measles: When to vaccinate?

The measles outbreak reported in the article "Outbreak of measles in a highly vaccinated secondary school population" (*Can Med Assoc J* 1996;155:1407-13), by Drs. Penny A. Sutcliffe and Elizabeth Rea, is one of many such outbreaks during the last several years in North America. These outbreaks prompted our southern neighbour to switch to a 2-dose measles-vaccination strategy a long time ago. The article and the accompanying editorial "Elimination of measles in the Americas" (*Can Med Assoc J* 1996;155:1423-6), by Dr. John Furesz, support a 2-dose strategy to eliminate measles. However, the timing of the 2 doses is an issue that remains to be settled.

In all Canadian provinces, the first dose of measles–mumps–rubella (MMR) vaccine is administered at 12 months of age, except in PEI, where it is given at 15 months. In the new 2-dose strategy, a second dose is given at 18 months in Newfoundland, Quebec, Saskatchewan, BC, Yukon and the Northwest Territories, and at 4 to 6 years in PEI, Nova Scotia, Ontario, Manitoba and Alberta. Both schedules are consistent with the recommendations of the National Advisory Committee on Immunization.

Our studies of measles-vaccine response, vaccine failure and waning immunity shed some light on the timing of the 2 doses. Our data show that up to 16% of children who receive the first dose of MMR vaccine at 12 months do not respond adequately and remain without protective immunity after the first dose.[1,2] This lack of immunity cannot be attributed entirely to maternal measles