fact that health care never became a hot election issue last June says nothing about its priority for the new government.

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Spirometric testing and the breathalyser

Our recent criminal court experience supports the caution to physicians contained in "Don't use medical excuses to escape breathalyser, MDs warn" (*Can Med Assoc J* 1997;156:157).

A 61-year-old man was arrested for operating a motor vehicle while impaired by alcohol. At the police station he did not provide a suitable breath sample for the breathalyser, citing "shortness of breath" from smoking and work in a dusty area that day. The breathalyser technician noted that the accused did not blow hard enough to raise the piston, and no exhalation or venting was detected after several attempts.

A physician wrote that the accused had "a degree of chronic destructive [sic] lung disease," and with no objective spirometric data concluded that it would be difficult for the accused to provide a breath sample for the breathalyser.

At trial, a videotape of the accused taken at the police station showed he had no apparent breathing problems while walking or talking. The physician testified that the accused had some degree of chronic obstructive pulmonary disease (COPD), but upon cross-examination admitted it was not severe enough to warrant spirometric testing.

In a study of 10 patients with known COPD, all were able to provide an adequate sample for the breathalyser. These patients (aged 56 to 78 years) had a forced expiratory volume in 1 second (FEV_1) between 0.46 and 1.86 L and a ratio of FEV_1 to forced vital capacity of from 0.19 to 0.53.[1]

Our experience is that objective spirometric testing, showing significantly diminished values, is required for reliable testimony in these types of cases. In this case, the accused was convicted of failing to provide a breath sample.

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Reference

1. Wilson A, Sitar DS, Molloy WD, McCarthy D. Effect of age and chronic obstructive pulmonary disease on the breathalyser estimation of blood alcohol level. *Alcohol Clin Exp Res* 1987;11(5):440-3.

Drug- and caffeine-induced headaches

The article "Guidelines for the diagnosis and management of migraine in clinical practice" (*Can Med Assoc J* 1997;156:1273-87), by Dr. William E.M. Pryse-Phillips and associates, is an excellent overview. On the basis of my personal and practice experience, I would like to see more emphasis on the importance of drug-induced and caffeine-induced headaches. Anyone with frequent headaches (more than 2 per week) should be carefully questioned about intake of caffeine and use of over-the-counter and prescription drugs.

Acetaminophen and NSAIDs are the drugs least likely to cause headaches. Anything else needed to relieve headache pain (including sumatriptan) is prone to causing rebound headaches when withdrawn.

The initial management should involve identification and avoidance of triggers, careful and sensitive provision of information, the simplest single analgesic, rest, ice and massage. An appropriately informed patient can then be his or her own headache expert, detective and healer.

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[The principal author responds:]

I certainly agree with Dr. Shea that there are several areas to do with migraine that require emphasis for their optimal management in Canada.

Our article was written according to the strict requirements for guidelines based on randomized controlled trials. Very few of the nonpharmacologic therapies have been subject to such analyses; as a result, they could not be included. As we mentioned in the article, we have decided to perform a separate review of all such therapies, including acupuncture, biofeedback and hypnosis.

The whole problem of drug-induced headache is a very important one. We referred to it briefly in our article but, to my knowledge, no firm guidelines for diagnosis have yet been constructed and agreed upon, although this work is in progress.

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Feverfew products

The article "Herbal products begin to attract the attention of brand-name drug companies" (*Can Med Assoc J* 1996;155:216-9), by Kate Cottrell, contains some errors.

The Health Protection Branch (HPB) of Health Canada regulates botanical products under its Food and Drug directorates. If a product is classified as a drug, usually after a manufacturer makes a therapeutic