first year of data collection will be presented at the Canadian Cardiovascular Congress in October.

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Telehealth revisted

Regarding the recent discourse in *CMAJ* on telehealth,[1] recognizing that the ability to access information by phone is important to patients, I rarely find that what they describe fits with the model we use to make diagnoses and determine treatment. It would be useful to study the accuracy of this method of treatment. One of my most significant moments in practice was in attempting to make a diagnosis over the phone. In this case, I would easily have missed the diagnosis if I did not have so little faith in telephone consultation.

I had finished my first year of practice. At the end of a morning clinic I received a request for what type of lozenges would be best for a sore throat. This request came to me on a piece of paper with the caller waiting. The person calling had never been seen at our clinic nor had her son for whom she was calling. We had no medical information and she was more than 15 miles away. I spoke with her directly, as was my habit in all such instances.

She stated that her toddler had a sore throat. My response was based on rarely being able to get toddlers to say anything about their symptoms. How did she know it was sore? Her response was "It's obvious from his drooling." With much effort and encouragement I was able to talk the mother into bringing in the child and able to make the diagnoses of epiglottis. He required intubation shortly after.

How can we expect a telephone response system bombarded with upper respiratory calls to separate out such isolated cases? What protocol can help a mother who does not think her child is significantly ill?

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Disordered eating behaviours

Jones and colleagues reported an alarmingly high prevalence of disordered eating behaviours in a community sample of adolescent girls.[1] This study is a valuable addition to the research literature on adolescent dieting. However, the language they used in describing their findings may be easily misinterpreted.

On the basis of the percentage of girls surveyed who scored above a cut-off score on the Eating Attitudes Test-26 (EAT-26),[2] the authors stated that disordered eating attitudes and behaviours were present in over 27% of girls aged 12–18 years. Although the results provide information about the percentage of teenaged girls who show unhealthy dieting behaviours and are at increased risk of developing eating disorders, they do not provide information about the prevalence of disordered eating.

The authors of a recent review, one of whom was one of the authors of the EAT-26, concluded that the predictive validity of this instrument is poor because the prevalence of eating disorders is low (1 to 3%).[3] They recommended that the instrument not be used to establish the prevalence of disordered eating behaviours unless it serves as the first part of a 2-part diagnostic screen and the second part involves a clinical interview with high scorers.

I do not want to minimize the importance of the findings of Jones and colleagues, but they could have facilitated a more accurate interpretation of the results had they noted that the majority of girls who scored above the cut-off score of 19 on the EAT-26 may not actually have a disorder. The percentage of survey participants who score above the cut-off on a self-report screen cannot be equated with the prevalence estimate of a psychiatric disorder.

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[Three of the authors respond:]

We appreciate Frank Elgar's recent letter to the editor drawing attention to our study of disor-