

Canadian Adverse Drug Reaction Newsletter. These programs cost money and require a continued commitment. The regional centres struggle on paltry budgets to provide minimal service, the expert advisory committee has been all but abandoned and the use of high-quality provincial health databases is beyond the program's financial reach. Evidently, Health Canada does not understand that drug-induced illness is a major public health concern.

Setting up proactive surveillance programs would be a worthwhile endeavour in any country.⁶ The New Zealand Intensive Medicines Monitoring Program⁷ is a good example of what can be done at a reasonable cost. Health Canada would do well to explore this option once it decides to support pharmacovigilance in our country.

W.C. Appel

Principal

Kusuri Canada Corp.

Ottawa, Ont.

References

1. Postmarketing drug surveillance: what it would take to make it work [editorial]. *CMAJ* 2001;165(10):1293.
2. Sibbald B. Cisapride, before and after: still waiting for ADE-reporting reform. *CMAJ* 2001;165(10):1370.
3. Wilholm BE, et al. Spontaneous reporting systems outside the US. In: Strom BL, editor. *Pharmacoepidemiology*. 2nd ed. New York: Wiley & Sons; 1994. p. 142.
4. Wilholm BE, et al. Spontaneous reporting systems outside the US. In: Strom BL, editor. *Pharmacoepidemiology*. 2nd ed. New York: Wiley & Sons; 1994. p. 145.
5. Liu BA, Knowles SR, Mittmann N, Einarson T, Shear NH. Reporting of fatal adverse drug reactions. *Can J Clin Pharmacol* 2001;8(2):84-8.
6. Bortnichak EA, Wise RP, Salive ME, Tilson HH. Proactive safety surveillance. *Pharmacoeconom Drug Saf* 2001;10:191-6.
7. Coulter DM. The New Zealand Intensive Medicines Monitoring Program. *Pharmacoeconom Drug Saf* 2000;4(9):273-80.

Clinicians' role in responding to bullying

I read with great interest Erica Weir's Public Health article on the potentially harmful impact of bullying on victims' psychosocial adjustment.¹ As a high percentage of children and adolescents are exposed to bullying with-

out adequate intervention from school personnel, parents or mental health professionals,² I was particularly pleased to read Weir's discussion about the role of clinicians in responding to peer victimization.

In addition to enhancing the self-esteem of the victim, psychotherapy can address the contribution of psychiatric symptomatology, namely difficulties with social anxiety, to problematic peer relationships. Socially anxious people typically experience cognitive, behavioural and physiological symptoms in anticipation of or during social interactions. Such symptoms are often associated with difficulty in peer relations, as overt anxiousness may interfere with the development of social skills and friendships.³ In addition, the overt anxiety displayed by some victims may make them vulnerable to peer maltreatment because they present easy targets to bullies.⁴

Eric A. Storch

Department of Clinical Psychology

Teachers College

Columbia University

New York, NY

References

1. Weir E. The health impact of bullying. *CMAJ* 2001;165(9):1249.
2. Slee P. Situational and interpersonal correlates of anxiety associated with peer victimization. *Child Psychiatry Hum Dev* 1994;25:97-107.
3. Inderbitzen H, Walters K, Bukowski A. The role of social anxiety in adolescent peer relations: differences among sociometric status groups and rejected subgroups. *J Clin Child Psychol* 1997;26:338-48.
4. Troy M, Sroufe A. Victimization among preschoolers: role of attachment relationship history. *J Am Acad Child Adolesc Psychiatry* 1987;26:166-72.

Air travel and venous thromboembolism — the jury is still out

Recent correspondence by Michael Mant states that the association between air travel and venous thromboembolism is weak.¹ However, more evidence has appeared in the literature in the last few months on this association. A recent study found that distance

travelled is a significant contributing risk factor for pulmonary embolism associated with air travel.² In this study, the rate of pulmonary embolism was 4.8 cases per 1 000 000 passengers for those travelling more than 10 000 km, and 1.5 cases per 1 000 000 for 5000 km of travel, as compared to 0.01 cases per 1 000 000 among those travelling less than 5000 km.

Symptomless deep vein thrombosis (DVT) might occur in up to 10% of long-haul airline travellers, and the wearing of elastic compression stockings during long-haul air travel is associated with a reduction in symptomless deep vein thrombosis.³

A report from the House of Lords in the United Kingdom entitled *Fifth Report: Air Travel and Health* has reviewed the evidence available and put forward certain recommendations to prevent deep vein thrombosis based on the baseline risk of the passengers.⁴

Finally, information for air travellers on ways to prevent venous thromboembolism is abundant on the Internet. The Web site www.airhealth.org has produced an excellent information sheet.⁵ Travellers can print it off and carry it with them. Some interesting tips on in-flight exercises can also be found from the Web site of Qantas.⁶

The jury is still out on this association, and we can expect a verdict as more high-quality evidence emerges in the literature.

Padmanabhan Badrinath

Clinical Assistant Professor &

Epidemiologist

Faculty of Medicine & Health Sciences

UAE University

Al-Ain, United Arab Emirates

References

1. Mant MJ. Air travel and venous thromboembolism [letter]. *CMAJ* 2001;165(8):1006.
2. Lapostolle F, Surget V, Borron SW, Desmaizieres M, Sordet D, Lapandry C, et al. Severe pulmonary embolism associated with air travel. *N Engl J Med* 2001;345:779-83.
3. Scurr JH, Machin SJ, Bailey-King S, Mackie JJ, McDonald S, Smith PD. Frequency and prevention of symptomless deep-vein thrombosis in long-haul flights: a randomised trial. *Lancet* 2001;357:1485-9.
4. Select committee on science and technology. Deep vein thrombosis, seating and stress. In: *Fifth report: air travel and health*. London (UK): House of Lords; 15 Nov 2000. Available:

www.publications.parliament.uk/pa/ld199900/ldselect/ldsctech/121/12109.htm#a78 (accessed 2001 Nov 19).

5. Here is what you need to know to reduce your risk of thrombosis injury. Available: www.airhealth.org/ENGLISH.PDF (accessed 2001 Nov 19).
6. Pre-flight essentials: your health inflight. Available: www.qantas.com.au/flights/essentials/healthinflight.html (accessed 2001 Nov 19).

Clarifying chiropractic manipulation risks

I read with great interest the commentary by Moira Kapral and Susan Bondy¹ on the elegant study by Scott Haldeman and colleagues² estimating the risk of vertebral artery dissections following chiropractic manipulation. Kapral and Bondy succinctly summarized some of the main difficulties that investigators face in attempting to determine the true risk of vertebrobasilar

accidents (VBA) following cervical manipulation.

However, I was surprised that Kapral and Bondy claimed that the population-based case-control study from Ontario estimating the risk of stroke from chiropractic manipulation³ "placed the risk of stroke for individuals aged under 45 years at about 1.3 per 100 000 chiropractic visits." In fact, careful reading of this article demonstrates that it actually stated that "for every 100 000 persons aged < 45 receiving chiropractic, approximately 1.3 cases of VBA attributable to chiropractic would be observed."

Each chiropractic patient frequently receives a series of visits, and thus it is essential to clearly differentiate between the number of chiropractic patients and the number of chiropractic visits. Careful discrimination between these concepts is especially crucial in this discussion, because the study by Haldeman and colleagues estimates the incidence

of stroke following a chiropractic treatment at 1 per 8.06 million chiropractic office visits and 1 per 5.85 million cervical treatments and because Kapral and Bondy seem to imply that these figures are significant underestimates.

William J. Lauretti

Chiropractor
Bethesda, Md.

References

1. Kapral MK, Bondy SJ. Cervical manipulation and risk of stroke. *CMAJ* 2001;165(7):907-8.
2. Haldeman S, Carey P, Townsend M, Papadopoulos C. Arterial dissections following cervical manipulation: the chiropractic experience. *CMAJ* 2001;165(7):905-6.
3. Rothwell DM, Bondy SJ, Williams JL. Chiropractic manipulation and stroke: a population-based case-control study. *Stroke* 2001;32:1054-60.

Corrections

The commentary by Moira Kapral and Susan Bondy concerning cervical manipulation and risk of stroke contains an error.¹ In the fourth paragraph, the sentence that begins "This placed the risk of stroke for individuals aged under 45 years at about 1.3 per 100 000 chiropractic visits ..." should instead begin as follows: "This placed the risk of stroke for individuals aged under 45 years at about 1.3 per 100 000 people who had had one or more chiropractic visits in the previous week ..."

Reference

1. Kapral MK, Bondy SJ. Cervical manipulation and risk of stroke. *CMAJ* 2001;165(7):907-8.

In a recent *CMAJ* article by Serge Gauthier,¹ in the first paragraph under the heading "Management of Alzheimer's disease" (page 618), reference 11 should appear 3 lines below its current location, after the phrase "at home." Also, in Table 3 of the same article the protein binding of galantamine should read 18%.

Reference

1. Gauthier S. Advances in the pharmacotherapy of Alzheimer's disease [review]. *CMAJ* 2002;166(5):616-23.

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Miacalacin

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New material