Headaches due to arachnoid leak

I found the report by Jana Thoennissen and colleagues on bed rest after cervical or lumbar puncture to be a very searching study.[1] If a patient experiences headaches post-puncture while in an upright position and the headaches are relieved by recumbency, it means there is an arachnoid leak. Every neurosurgeon who has done a laminectomy over the puncture site has occasionally seen pulsating extrusion of fluid at the dural opening. This often occurs because a "wick" of arachnoid has been dragged back through the dura as the needle is removed. This wick keeps the arachnoid open through the dura. It occurs because the needle struck bone on the way in, creating a miniature barb on the needle. If bone is struck on the way in, the needle should be discarded and a new one used.

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Reference

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Telehealth a medicolegal quagmire?

I have to chastise *CMAJ* gently about the statement in a news piece that Canada's telehealth services "trace back ... 10 years."[1] Equally erroneous was the assertion that "the telehealth model was originally imported from the US."

In 1973/74 we received an Opportunities for Youth grant through the Queen's University Alma Mater Society (AMS) to create a "Teleclinic." Our preliminary research at Kingston-area emergency departments had pointed to large numbers of nonurgent visits that might have been discouraged by better patient education.

The Teleclinic was staffed by medical and other health sciences students, and our mission was to provide advice by phone to people concerned about a health problem and wondering whether they should visit the emergency department. We trained the students and developed a series of "protocols" or "pathways" based on common complaints such as headache, GI bleeding and dyspnea or cough. Initially a couple of students worked at it for the summer. When the grant ran out, the project was funded by the AMS and staffed by student volunteers; it became a year-round service. It was popular and well used.

After I became an emergency physician, I decided that the project was in fact a medicolegal quagmire and I argued for its closure. Similar projects were briefly popular in the US with the advent of managed care in the early to mid-1990s. More recently, however, the American College of Emergency Physicians and most other responsible professional bodies have opposed any requirement that patients seek approval before visiting an emergency department.

Providing medical advice over the phone to unknown patients is potentially dangerous. In the US, it clearly discouraged some essential visits. Unless a physician is providing advice based on knowledge of that particular patient, a predictable number of wrong decisions will be made and the wrong advice provided.

Yes, the advice is usually correct and the visit is unnecessary. But what price a human life?

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1. Lightstone S. Health-care-by-phone services spreading across country. *CMAJ* 2002;166(1):80.

Orwellian paranoia in the neonatal ICU

The recent commentary in *CMAJ* on neonatal intensive care units is more likely to produce Orwellian paranoia than any tangible benefits.[1] It is just too easy to prematurely reveal incomplete or flawed data analyses,

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