

supplied to the registry. Registries should use appropriate methods for assessing these criteria.

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The best protection

The transmission of the virus causing severe acute respiratory syndrome (SARS) appears to be by aerosol droplet and possibly through other routes.¹ Therefore, it is recommended that health care workers and others who may be exposed¹ employ respiratory and other personal protective equipment.^{2,3} The type of respirator that has typically been used by health care workers is the N95 half-mask.^{2,3} As correctly stated by Richard Schabas,² the “N95-rated mask” is 95% filtration efficient,⁴ but does this level of efficiency provide the best protection for those at risk of exposure? The effectiveness of the N95 respirator has been supported by a small study on prevention of occupational transmission of infection.¹ However, for work with bacterial bioaerosols and chemical and biological warfare agents, some have suggested that N95 masks are inappropriate^{5,6} because these respirators do not provide “absorbent capability” and because of the amount of mask leakage, which can be about 5% through the filter and 10% around the mask,⁷ even if properly fitted. For biological diseases like SARS, for which just a few particles may be sufficient for infection, the N95 mask may indeed be inadequate, and some health care workers may therefore become infected even if they use the respirator properly.

A better selection for respiratory

protection would be an N100 respirator with an ultra-low penetrating air filter (ULPA), which would cost only slightly more than an N95 respirator. N100 respirators have an efficiency of 99.977%,⁸ and ULPA filters are 99.999% efficient for monodispersed particles 0.12 µm in diameter or larger.⁹ HEPA (high-efficiency particulate air) filters would not be the best selection for use with a respirator because their efficiency is 99.97% for monodispersed particles 0.3 µm in diameter or larger, and coronaviruses are smaller than this (at about 60 to 200 nm). For effective operation of an N100 respirator with ULPA, the user must be fit-tested. The United States and many other countries have numerous requirements for using a negative-pressure air-purifying respirator, including medical evaluation and training, as well as yearly fit-testing.

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Compassionate care

As one of the physicians consulted on Human Resources Development Canada’s new compassionate leave program for people caring for gravely ill or dying children, parents or spouses, I was disappointed by the title, tone and emphasis of the *CMAJ* news item on this topic.¹ This is just the type of program that Canadian physicians should support and take pride in. Emphasizing that this benefit entails “more paperwork for physicians” is misguided at best and makes Canadian physicians appear small minded. A more positive headline might have been “New federal program supports compassionate care for ill family members.”

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1. Lai T. MDs will have to sign off on new compassionate care applications. *CMAJ* 2003;168(7):886.

The perils of PDAs

Last June I purchased an anesthesia database derived from a popular textbook and distributed by one of the software houses mentioned in the review by Feisal Adatia and Philippe Bardard.¹ In February, one day after the guarantee on my handheld computer expired, the unit also expired.

After purchasing a new unit, I performed a “hotsync” and successfully transferred all material from the old handheld to the new unit, except the anesthesia database mentioned above. Because the device ID of the new unit was different from that of the old one, it was impossible to unlock and transfer the program.

I telephoned the company long distance but was unable to reach a human being. My request for a return call, left on the company’s voice-mail system, produced no response, and I’ve had no