It's not the law

Malvinder Parmar's Clinical Vistas article[1] illustrates a Courvoisier gallbladder handsomely. Parmar aptly and carefully notes the occurrence of exceptions, whereby nothing more ominous than cholelithiasis and chronic cholecystitis underlie painless jaundice with a palpable gallbladder. Thus, for clarity, we should stop calling the sign of Courvoisier a "law," which by definition must apply to all. This point is made in a wonderful short review of the phenomenon, and of Courvoisier's important place in the history of medicine, which was published 17 years ago by Verghese and associates.[2]

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References
1. Parmar MS. Courvoisier's law. *CMAJ* 2003;168(7):876-7.
2. Verghese A, Dison C, Berk SL. Courvoisier's "law" — an eponym in evolution. *Am J Gastroenterol* 1987;82:248-50.

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[The author responds:]

I agree that, because of the exceptions, Courvoisier's law[1] is not really a law. In the truest sense of the word, laws are rules created by the state or the courts, not medical observations. This particular observation has also been referred to as Courvoisier's sign[2] and Courvoisier's gallbladder,[3] but none of the terms were coined by Courvoisier.

Over a century ago, in 1890, Courvoisier presented his observation that a palpable gallbladder in a patient with obstructive jaundice is often caused by a noncalculus abnormality of the hepatobilliary system (e.g., pancreatic cancer or stricture of the common bile duct). He qualified this observation by stating that "if further evidence of this can be found, this would be an important marker for differential diagnosis."[4] At what point the observation came to be referred to as a "law" is not clear, but it was acclaimed as such as early as 1905.[5] More exceptions were noted later, which eventually led to skepticism about the "law," although most studies that have examined its validity[6] have confirmed the general trend of Courvoisier's observation. Chung[3] observed that high-grade obstruction of the common bile duct over a prolonged period (which is likely with pancreatic carcinoma but can also occur with stones) is responsible for dilatation of the gallbladder in patients with obstructive jaundice, and this theory would explain the various exceptions to Courvoisier's gallbladder that have been noted in the literature. Verghese and Berk[7] suggested that "Clarity might be restored to this murky field by changing the eponym to 'Courvoisier's gallbladder.'"

There is no consensus on the proper eponym for this observation, but this has become an academic exercise because technological advances and early interventions in patients with gallstones or jaundice mean that the problem is usually addressed before it reaches this stage.

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References
1. Parmar MS. Courvoisier's law. *CMAJ* 2003;168(7):876-7.
2. Fournier AM, Michel J. Courvoisier's sign revisited: two patients with palpable gallbladder. *South Med J* 1992;85(5):548-50.
3. Chung RS. Pathogenesis of the "Courvoisier gallbladder." *Dig Dis Sci* 1983;28(1):33-8.
4. Verghese A, Dison C, Berk SL. Courvoisier's law — an eponym in evolution. *Am J Gastroenterol* 1987;82:248-50.
5. Moyniham BGA. *Gallstones and their surgical treatment*. 2nd ed. Philadelphia: WB Saunders; 1905.
6. Mikal S, Campbell AJA. Cancer of the pancreas: diagnostic and operative criteria based on 100 consecutive autopsies. *Surgery* 1950;28:963-7.
7. Verghese A, Berk SL. Courvoisier's law [letter]. *Lancet* 1986;1(8472):99.

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Time management

Here are some additional time-management suggestions to add to those of John Crosby.[1] If a patient has more than 3 prescriptions, I use a square of carbon paper to copy my script directly into the chart. A bonus of this system is that it provides evidence for the not-infrequent disputes with pharmacies over number of refills and other aspects of the prescriptions. And for the one patient who is using a large number of herbs, vitamins, medications and shampoos, I have a preprinted large-size script page listing all of the items; at any particular visit, I simply initial the items requested.

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Reference
1. Crosby JW. Ten time-management tips for family physicians. *CMAJ* 2004;170(6):949-50.

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I have 2 suggestions to add to John Crosby's time-management tips for physicians.[1]

Preprinted problem lists, with their myriad columns for patient data such as cholesterol level and date of most recent mammogram, promise better organization of information, but physicians would be better off throwing these directly in the garbage. A rule of thumb is "The more complicated the form, the less likely you are to bother filling it out." Instead, take a blank sheet of paper and write the patient's name at the top. Down the left-hand side list the patient's medical problems, and across from each problem, on the right-hand side of the page, list the medications prescribed. At the bottom of the page, list any medication allergies. Make this page the first page of the patient's chart, facing inward to save flipping back and forth. Any patient who is receiving more than one medication should have a problem list like this.

My second suggestion relates to eliciting wheezing in patients with asthma. Some patients find it difficult to understand the physician's instructions to blow out forcefully, and for small chil-

dren this may be impossible. Instead, reach for a child's pinwheel. Blow on the pinwheel to make it spin and then hand it to the patient, saying "Wait while I put my stethescope back on your chest — okay, now blow!" This inexpensive equipment can save a lot of explanation.

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Reference

1. Crosby JW. Ten time-management tips for family physicians. *CMAJ* 2004;170(6):949-50.

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A national public health system

It was with surprise and disappointment that I read the commentary by Carolyn Bennett,[1] the minister of state for public health. The mandate of Canada's new Public Health Agency is to improve Canada's ability to deal with new and emerging infectious diseases and to improve our nation's emergency preparedness. Presumably, Bennett believes there may be some small role for Canada's emergency departments in meeting this challenge. If so, she will need to spend some time reversing the effects of a decade of neglect on Canada's emergency health system.

Recent reviews have highlighted concerns about the ability of Canadian emergency departments to respond to emerging infectious diseases and terrorist attacks.[2,3] Indeed, current conditions in our nation's emergency departments profoundly affect their ability to provide timely care for even routine emergencies, let alone a national public health emergency.

Many of our emergency departments suffer from a lack of operational support, are insufficiently staffed, are chronically overcrowded and have no recognizable regional response plans. It would not be unreasonable to suggest that these problems are directly attributable to insufficient government attention. Rather than being members of the "tyranny of the acute," most emergency physicians might more readily see themselves as oppressed victims of government neglect.

Good for Bennett for addressing the deficiencies of the national public health system. However, if she is truly concerned with our preparedness to meet national health emergencies, she must spend some time reversing the chronic neglect of Canada's emergency departments.

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References

1. Bennett C. Building a national public health system [editorial]. *CMAJ* 2004;170(9):1425-6.
2. Ovens H, Thompson J, Lyver M, Murray M, Innes G, on behalf of Canadian Association of Emergency Physicians. Implications of the SARS outbreak for Canadian emergency departments. *Can J Emerg Med* 2003;5(5):343-7.
3. Kollek D. Canadian emergency department preparedness for a nuclear, biological or chemical event. *Can J Emerg Med* 2003;5(1):18-25.

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Match or mismatch?

Patrick Sullivan[1] reports that 177 residency positions remained unfilled after the first iteration of this year's resident match, but I am unclear why he believes that the 71 unmatched Canadian medical students "should match easily when the second iteration is held."

The Canadian Resident Matching Service projects that for the second round of matching, 758 international medical graduates will also be competing for those same 177 positions.[2] These numbers are bad news for everyone involved, including the Canadian public, who would benefit greatly if funding were made available to train each and every one of these qualified students as soon as possible.

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References

1. Sullivan P. Students still ambivalent about family medicine. *CMAJ* 2004;170(9):1380.
2. *Forecast for 2004 second iteration match*. Ottawa: Canadian Resident Matching Service; revised 2004 Mar 25. Available: www.carms.ca/matchProjection 2nd.html (accessed 2004 May 6).

DOI:10.1503/cmaj.1040764

Correction

An article about the Jean Chrétien Pledge to Africa Act[1] incorrectly stated that developing nations that will be permitted to import generic versions of brand-name patented drugs can only do so for public health emergencies. In fact, there is now no such restriction on the importation of the drugs. We regret this error.

Reference

1. Eggertson L. Cheaper HIV/AIDS drugs coming. *CMAJ* 2004;170(13):1905.

DOI:10.1503/cmaj.1041127