more concerned about the potential impact on public health. The medical community must become more aggressively involved in combating future global environmental problems.

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References

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Choice of antihypertensives after acute ischemic stroke

Andrea Semplicini and Lorenzo Calò address the thorny issue of managing hypertension in the setting of acute ischemic stroke. They emphasize the importance of selecting rapidly reversible agents “in case neurologic signs and symptoms worsen with the blood pressure reduction.” They also mention the recommendations of both the American Stroke Association and the European Stroke Initiative in selecting an appropriate pharmacologic agent, either labetalol or sodium nitroprusside.

Labetalol given intravenously has an onset time of 5 minutes, a peak effect at 20–30 minutes and a duration of action of 3–6 hours. In contrast, sodium nitroprusside has an onset time of less than 1 minute, a peak effect at 1–2 minutes and a duration of effect of 2–5 minutes. Given these differences, there really a role for labetalol (or any other agent, save intravenous nitroglycerin if acute myocardial ischemia is a concern) in a setting where the ability to rapidly titrate the drug to effect is of serious import?

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References

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Rehabilitation and acute stroke care

Quality-of-care indicators provide an important framework for developing consistent high-quality care. The commentary by Patrice Lindsay and associates provides a framework for acute stroke care but fails to address the necessary link to rehabilitation services.

Although rehabilitation is acknowledged in the article’s online appendix as an important component of stroke care, the lack of a specific indicator addressing this link during acute care diminishes the importance of timely assessment of rehabilitation needs.

[The authors respond:]

We did not discuss the relative merits of labetalol and sodium nitroprusside in our article, and thank Seamus Donaghy for pointing out the differences in duration of action between these 2 drugs.

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There exists strong evidence that interdisciplinary stroke rehabilitation leads to better functional outcome than does usual care.1 Although there is less evidence regarding the timing of rehabilitation, the need for such services must be determined during acute care to avoid missing this important component of overall stroke care.

We therefore propose that an additional indicator be included for optimal stroke care: timely assessment for rehabilitation when appropriate.

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References

Are children with type 1 diabetes immunocompromised?

In their clinical report of a 4-year-old child with leukemia and an enlarging arm lesion that proved to have been caused by an opportunistic fungus, Ahmed Mater and associates' state that "[i]nfections generally occur in immunocompromised patients with conditions such as neutropenia, diabetes or hematologic malignant disease.4 This statement implies that all patients with type 1 or type 2 diabetes mellitus are immunocompromised. Our interest is children (up to 18 years of age) with type 1 diabetes, and we challenge the accuracy of the statement in this context.

Mater and associates' cite 2 papers2,3 that listed “diabetes,” specifically diabetes complicated by ketoadisis, as a risk factor for opportunistic infections. However, those articles did not provide evidence to support this claim in children with type 1 diabetes. Is there any evidence to show increased rates of infection or prolonged recovery from infection in children with type 1 diabetes? In-vitro data have demonstrated impaired immune function due to hyperglycemia and/or hypoinsulinemia in association with type 1 diabetes.4,5 However, those studies did not show that the differences in cell-mediated and humoral immune function translate into significant morbidity or mortality in the clinical setting. In fact, the humoral response to influenza vaccine in patients with type 1 diabetes is no different from that of controls with respect to protection rates.6 The incidence of candidal infection is greater

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