private and public drug plans. That’s
good public policy.

Jane Farnham
Chair of the Board
Ontario Pharmacists’ Association
Toronto, Ont.

References
1. Emergency contraception moves behind the

A recent CMAJ editorial1 expresses
concern that the reclassification of
levonorgestrel 0.75 mg (Plan B) as a
“behind the counter” product repre-
sents a “needless barrier to access.”

The National Association of Phar-
cacy Regulatory Authorities strongly
believes that incorporating pharmacists’
counselling in the provision of emer-
gency contraceptives benefits women
and the health care system. Pharmacists
can play a key role in educating women
on the risk of infection associated with
unprotected sex, the correct use of bar-
rrier and hormonal contraception and
the management of side effects of this
medication. Women will have the op-
tion of visiting a physician or a pharma-
cist and thus will be able to make their
own decision on the initial point of care.

Given the experience in British Co-
lumbia of a “dramatic rise” in the total
use of emergency contraceptives “re-
sulting mainly from pharmacy dispens-
ing” (to quote the CMAJ editorial), it is
difficult to understand how consulta-
tion with the pharmacist presents a bar-
rrier to access. Licensed pharmacists
possess the knowledge, skills and pro-
fessionalism needed to sensitively sup-
ply emergency contraception.

Lois Cantin
President
National Association of Pharmacy
Regulatory Authorities
Ottawa, Ont.

References
1. Emergency contraception moves behind the

Physicians and advocacy

It is evident that providing responsible
advocacy for patients, individually and
collectively, is an obligation for Canadian
physicians, as was discussed in a CMAJ
editorial1 earlier this year. The College of
Family Physicians of Canada has distrib-
uted a Declaration of Commitment,
dated Nov. 25, 2004, that states “we are a
resource to our practice populations —
promoting health to prevent illness, pro-
viding and explaining health information,
collaborating with and facilitating access
to other caregivers, and advocating for
patients throughout the health care sys-
tem.” The Educating Future Physicians
for Ontario project identified “advocate”
as one of the roles patients expect from
their physician. Similarly, the Royal Col-
lege of Physicians and Surgeons of
Canada’s CanMEDs roles include the
role of “advocate.”

Even if such advocacy makes admin-
istrators uncomfortable, physicians
must judge what is in the best interests
of their patients and behave accord-
ingly. We must strive for communica-
tion within institutions that ensures
that medical staff can make good judg-
ments about how best to exercise their
responsibility for advocacy, but we
must never stifle their voices. There
are too many historical examples of
suppression of information when pa-
tients would have benefited from
prompt disclosure.

Carol P. Herbert
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Dentistry
Professor, Family Medicine
University of Western Ontario
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Reference
1. Physicians and advocacy [editorial]. CMAJ 2005;
172(11):1413.

A novel mutation in a patient
with pantothenate kinase–
associated neurodegeneration

Pantothenate kinase–associated neu-
rodegeneration is an autosomal re-
cessive disorder characterized by accu-
mulation of iron mainly in the basal
ganglia.1,2 In about half of these cases,
patients have an identifiable mutation
in the PANK2 gene.1

We previously described a 13-year-
old boy who showed the “eye of the
tiger” sign on a T2-weighted magne-
tic resonance (MR) image3 that is highly
specific not only for this disease but
also for a mutation in the PANK2
gene.1 Here we report on our screening
for mutations of the PANK2 gene con-
ducted on the genomic DNA of the pa-
tient and his family (Fig. 1).

DNA was isolated from peripheral
blood using a phenol-chloroform refer-
ence protocol. All exons of the gene
were amplified by polymerase chain re-
action (PCR),4 and the amplified prod-

578
JAMC • 13 SEPT. 2005; 173 (6)