made changes that we felt best accommodated the limitations of the labelling equipment and that we interpreted as acceptable for small labels. Of note, the generic name has always been included on the outer package.

Importantly, when we received concerns, we took measures to change the label. These included informing the Institute for Safe Medication Practices about the absence of the generic name on the Polyamp®, and working with our colleagues to make equipment modifications enabling the inclusion of the generic name. With regard to existing stock, we investigated the option of attaching pre-printed labels to the Polyamp®. This was considered unacceptable, as it could have compromised the safety of the product due to potential leaching of adhesive through the Polyamp® into the solution.

AstraZeneca collaborated with the Health Products and Food Branch Inspectorate to manage the existing product and the introduction of product with revised labelling. In addition, we alerted customers and Drug Information Centres regarding the introduction of product with revised labelling and the option to exchange existing stock. We also destroyed all of our stock with the previous labelling and replaced returned inventory with newly labelled product.

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DOI:10.1503/cmaj.1050238

Corrections

In recent Analysis article,[1] the second figure illustrating the cases of invasive pneumonoccocal infection among adults 65 years and older was incorrect. The correct figure, Fig. 1, is included here.

REFERENCE

1. Kellner J, Church DL, MacDonald J, et al. Progress in the prevention of pneumoccocal infection. *CMAJ* 2005;173(10):1149-51.

DOI:10.1503/cmaj.051576

In a recent commentary,[1] it was stated that Health Canada uses the World Health Organization Good Clinical Practice (GCP) guideline. In 1997, Health Canada adopted the GCP guideline developed by the International Conference on Harmonization.[2] In notifying us of the error, Jean Saint-Pierre, coordinator at the Good Clinical Practice Unit at Health Canada, stated that the Health Products and Food Branch Inspectorate has been conducting GCP inspections on clinical trials. These inspections assess the level of compliance with GCP of qualified investigators conducting trials. Two summary reports of findings made during these inspections are publicly available.[3]

REFERENCES

1. Blackmer J, Haddad H. The Declaration of Helsinki: an update on paragraph 30 [editorial]. *CMAJ* 2005;173(9):1052-3.
2. Regulations amending the food and drug regulations (1024 – Clinical trials). Ottawa: Health Canada; 2001. Available: www.hc-sc.gc.ca/dhp-mps/compli-conform/clini-pract-prat/reg/1024_tc-tm_e.html (accessed 2005 Nov 28).
3. Available: www.hc-sc.gc.ca/dhp-mps/compli-conform/clini-pract-prat/report-rapport/index_e.html (accessed 2005 Nov 28).

DOI:10.1503/cmaj.051577

In a recent editorial on clinical practice guidelines,[1] it is stated that, according to the Common Drug Review, the cost of insulin glargine is 5 times as much as generic insulin. According to the Canadian Expert Drug Advisory Committee, the comparative prices for insulin glargine and NPH insulin of $5.50 and $1.60 per 100 units, respectively — that is, just over 3 times the cost of generic insulin.[2] We thank Mike Tierney, Director, Common Drug Review, for bringing this matter to our attention.

REFERENCES

1. Clinical practice guidelines and conflict of interest [editorial]. *CMAJ* 2005;173:1297.
2. Canadian Coordinating Office for Health Technology Assessment. *CEDAC Final Recommendation on Reconsideration and Reasons for Recommendation*. Available: www.ccohta.ca/CDR/cdr_pdf/cdr_submissions/Complete/cdr_complete_Lantus_2005Sept28.pdf (accessed 2005 Dec 8).

DOI:10.1503/cmaj.1050253

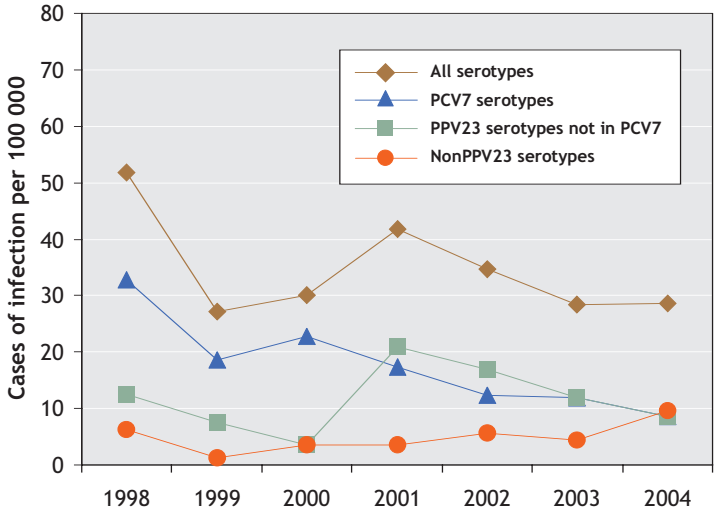

Fig. 1: Cases of invasive pneumococcal infection per 100 000 among adults 65 years and older according to year and serotype group. Data from CASPER Surveillance, 1998–2004 (χ^2 or Fisher exact test for comparisons). When compared with the combined rate between 1998 and 2001, the rate in 2004 decreased by 62.7% to 8.5 (95% CI 3.7–16.7) for PCV7 serotypes ($p = 0.007$); the change of 23.9% to 28.6 (95% CI 18.9–41.7) for all serotypes was not significant ($p = 0.24$), nor was the change of 24.1% to 8.5 (95% CI 3.7–16.7) for PPV23 serotypes that are not in PCV7 ($p = 0.59$). The increase of 163.9% to 9.5 (95% CI 4.4–18.1) for nonPPV23 serotypes was significant ($p = 0.03$).