through the blood system) that was close to his heart.² He considered that recommendation to be part and parcel of the precautionary principle because it would have served to balance the pressures of extreme risk aversion (by regulatory bodies and health care agencies, among others) with the need to move ahead with new treatments or to respond to unanticipated challenges. It put the dignity of patients first. Regrettably, it has not been adopted.

Krever recognized that blood is not another drug but rather a complex biological product that can never be completely characterized. Given this fact, his first recommendation was remarkably prescient. As we enter the world of targeted biopharmaceuticals, more and more of our therapies begin to look like blood products in their subtle complexity. My guess is that we are going to have to revisit the issue of no-fault compensation as part of a complete reframing of our drug development process, lest we stifle innovation or drive the costs of new drugs to unaffordable levels.

Harvey Schipper BASc(Eng) MD
Founding Member of the Board of Directors, Canadian Blood Services, Toronto, Ont.

Competing interests: None declared.

REFERENCES

1. Wilson K. The Krever Commission — 10 years later. *CMAJ* 2007;177:1387-9.
2. Krever H. Financial assistance for blood-associated injury. In: *Final report: Commission of Inquiry on the Blood System in Canada*. Ottawa: The Commission; 1997. p. 1034-9.

DOI:10.1503/cmaj.1070173

Colorectal cancer screening

In their editorial on screening for colorectal cancer, Alan Barkun and Ken Flegel exaggerated the screening rate for this disease in the United States.¹ They cited a survey in which adults over 50 years of age were asked if they had ever undergone fecal occult blood testing, sigmoidoscopy or colonoscopy.² Sixty-three percent of the respondents replied that they had; Barkun and Flegel cited this figure as evidence of greater uptake

of screening in the United States. However, only 37% of the respondents in that study were defined as being “current for testing” (that is, they claimed to have undergone fecal occult blood testing in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the last 10 years). This survey was subject to recall bias in 2 ways: some respondents might have wanted to show that they were aware of current screening recommendations (and thus they would have responded falsely that they had been screened) and some might have responded that they had been screened when in fact they had undergone these tests for investigation rather than screening purposes.

David Lieberman has estimated the rate of colorectal cancer screening in primary care in the United States to be between 26% and 32%.³ This rate is not much different from the rate in Canada and is not corrected to take into account patients without access to primary care.

Roy M. Preshaw MD
Lady Minto Hospital, Salt Spring Island, BC

Competing interests: None declared.

REFERENCES

1. Barkun A, Flegel K. Outliving colorectal cancer. *CMAJ* 2007;177:545.
2. Peterson NB, Murff HJ, Ness RM, et al. Colorectal cancer screening among men and women in the United States. *J Womens Health (Larchmt)* 2007; 16:57-65.
3. Lieberman D. Colorectal cancer screening in primary care. *Gastroenterology* 2007;132:2591-4.

DOI:10.1503/cmaj.1070140

[The authors respond:]

We thank Roy Preshaw for his letter in response to our editorial on colorectal cancer screening.¹ He unfortunately appears to have mixed up 2 separate rates reported in the US and Canadian studies. We correctly quoted the “ever-screened” rate in the United States as 63%²; the comparable rate in Canada is 23.5%.³ The difference between the “current-for-screening” rates in the 2 countries is similar in magnitude: 37% in the United States² and 17.6% in Canada.³

Preshaw’s assertion that colorectal

cancer screening rates in Canada and the United States are not so different is thus incorrect. In fact, no assertion could be further from the truth. There are overwhelming data showing that “current-for-screening” rates are approximately 43% to 55% in the United States^{4,5} whereas Canadian investigators have reported dismal data. For example, a “current-for-screening” rate of only 14% in Canada was recently reported.⁶

The reasons for these differences are likely multifactorial. However, a recent US study indicated that among primary care physicians and adults at average risk of developing colorectal cancer, lack of patient awareness and failure of a physician to recommend screening are key barriers to screening.⁷ We therefore reiterate our plea for Canadian physicians to actively work to close this care gap; such action will ultimately save lives.

Alan Barkun MDCM MSc
Chairholder, Douglas G. Kinnear Chair in Gastroenterology, McGill University, Montréal, Que.
Ken Flegel MDCM MSc
Senior Associate Editor, *CMAJ*

Competing interests: None declared.

REFERENCES

1. Barkun A, Flegel K. Outliving colorectal cancer. *CMAJ* 2007;177:545.
2. Peterson NB, Murff HJ, Ness RM, et al. Colorectal cancer screening among men and women in the United States. *J Womens Health (Larchmt)* 2007; 16:57-65.
3. Zarychanski R, Chen Y, Bernstein CN, et al. Frequency of colorectal cancer screening and the impact of family physicians on screening behaviour. *CMAJ* 2007;177:593-7.
4. Lemon S, Zapka J, Puleo E, et al. Colorectal cancer screening participation: comparisons with mammography and prostate-specific antigen screening. *Am J Public Health* 2001;91:1264-72.
5. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003;348:2635-45.
6. McGregor SE, Hilsden RJ, Li FX, et al. Low uptake of colorectal cancer screening 3 yr after release of national recommendations for screening. *Am J Gastroenterol* 2007;102:1727-35.
7. Klabunde CN, Vernon SW, Nadel MR, et al. Barriers to colorectal cancer screening: a comparison of reports from primary care physicians and average-risk adults. *Med Care* 2005;43:939-44.

DOI:10.1503/cmaj.1070176

Corrections

Box 4 in the review by Warburton and colleagues¹ should have listed the for-

mula to predict maximum heart rate in obese people as $200 - (0.5 \times \text{age})$.

REFERENCE

1. Warburton D, Nicol C, Bredin S. Prescribing exercise as preventative therapy. *CMAJ* 2006;174:961-74.

DOI:10.1503/cmaj.080217

Table 1 in the review by Le Foll and George¹ should have listed the number of pieces of gum for initial treatment of tobacco dependence as 12–16 pieces daily (2 or 4 mg polacrilex gum) and up to 20–24 pieces daily for breakthrough cravings and withdrawal symptoms. Table 1 should have also listed nicotine inhaler use as 6–12 puffs per day instead of 4–6.

REFERENCE

1. Le Foll B, George TP. Treatment of tobacco dependence: integrating recent progress into practice. *CMAJ* 2007;177:1373-80.

DOI:10.1503/cmaj.080218

A News article in the Jan. 29, 2008, issue about the lack of pharmacological training contains some inaccuracies in the information attributed to the Royal College of Physicians and Surgeons of Canada.¹ Clinical pharmacology, as a discipline, is not a required course at the postgraduate level. It is a 2-year subspecialty program that is offered by 4 of Canada's 17 medical schools. Residents who complete the program now

receive an “attestation” (confirmation of completion), but beginning in the fall of 2008, the college will begin a national certification examination for the subspecialty.

It should also be noted that only doctors who are Fellows of the Royal College participate in its mandatory maintenance of certification program.

CMAJ regrets these errors and apologizes for any inconvenience they may have caused.

REFERENCE

1. Young H. Lack of pharmacological training causes overuse and misuse of drugs. *CMAJ* 2008;178:276.

DOI:10.1503/cmaj.080246