

High sensitivity cardiac troponin testing

Bösner and colleagues have presented evidence for a simple rule for ruling out coronary artery disease in the primary care setting.¹ It is noteworthy that no laboratory measurements have been included in their model, with reference to their introductory statement that "... electrocardiography and cardiac troponin test are of limited value in primary care..."¹ This point deserves some discussion as the utility of cardiac troponin testing appears to be expanding in step with increasing assay sensitivity. With high-sensitivity assays clinically available — an example being the high sensitivity cardiac troponin T (TnT hs) assay now in use in Europe and available in Canada later this year, the ability to use this test in the primary setting for ruling out individuals at risk is an intriguing possibility. This is supported by recent studies in stable high-risk populations where the majority of individuals had measurable TnT hs concentrations,^{2,3} thus perhaps permitting interpreting TnT hs concentrations in the nonacute setting. More work is needed in this regard to establish cutoffs using the high-sensitivity assays in the primary care setting, but the ability to measure cardiac troponin in the stable setting is a provocative new route for possible risk stratification. Furthermore, even if these high sensitivity assays add prognostic information, an important question will remain whether inclusion of this marker to the existing five determinants will further improve an already impressive area under the curve of 0.90.¹

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Incorrectly placed C-spine collar

I don't question the research in this article¹ but rather the improper positioning of the C-spine collar on the cover of the Aug. 10 issue of *CMAJ*. The collar protrudes too far anteriorly (under the chin) and doesn't sit properly on the trapezius. This placement may result in serious injury if the chin slips under the collar during transport or a patient lift. An unfortunate portrayal of C-spine to accompany a good article.

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Medical education needed for smoking cessation

The editorial by Penz and colleagues rightly argues that governments can improve the health of populations by paying for smoking cessation.¹ Too often discussion of health care costs focuses on saving by reducing services to those who are sick, rather than by reducing the incidence of illness. Nevertheless, by concentrating on reimbursement for smoking cessation medications and products, Penz and colleagues ignore the need to pay for a more comprehensive approach to smoking cessation. All provinces have some

tobacco control policies, such as restrictions on advertising and on smoking in public places, which help to reduce smoking rates.

But for smoking cessation, it is clear that advice and counselling on behavioural strategies is effective, alone or in combination with pharmacologic therapy.² Provincial funding of smoking cessation must include reimbursement of physicians' time for counselling, as well as funding for other health professionals and programs to provide this service so that physicians do not carry this responsibility alone. However, physicians and other health professionals are not necessarily prepared by their education to provide smoking cessation counselling.^{3,4} Medical education, and education of other health professionals, must include training in counselling for smoking cessation and other preventive health behaviour.

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Governments, pay for smoking cessation

Your recent editorial correctly argues that provincial governments should provide funding for smoking cessation as it is a highly cost-effective way to improve population health.¹ Alas, the editorial then repeats a common error of confusing cost-effectiveness with

cost-saving. There is, in fact, good evidence that while smoking cessation may reduce health care spending over the medium term, in the longer term (15 to 30 years) health care spending is actually increased.²

The explanation for this is perfectly simple: nonsmokers live longer and therefore incur expensive health care costs in old age. These additional costs exceed the lower expenditures of earlier years. Quite apart from increased health care spending there would be two additional negative effects on government finances if all smokers quit: Governments would lose the hefty revenues generated by tobacco taxes, and there would be increased spending on pension payments.

This argument appeared in an analysis carried out by the British government in 1971. The report was never officially published but was leaked in 1980.^{3,4}

What applies to smoking also applies in other scenarios: the prevention of fatal diseases actually leads to an increase in health care spending.⁵

Indeed, our best evidence is that most medical interventions designed to prevent disease or improve health cause an increase in health care spending.⁶

Of course, the prevention of fatal diseases is undeniably of great value with regard to population health and should therefore be strongly supported. Moreover, prevention can often be much more cost-effective than many medical treatments.⁷ However, this is altogether different from decreasing health care spending.

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Polio immunity in Ontario

With reference to the article by King,¹ the population in Ontario cannot be considered to be fully immune to poliomyelitis when one considers the immune status of people 60 years of age and older. In all probability these individuals were never vaccinated against poliomyelitis during their infancy, childhood or adolescence. The vaccines were not available before 1960.

Such people could become infected with paralytic poliomyelitis if they were exposed to wild, live or vaccine-derived strains in the event of any importation and dissemination of the



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