Canadian Adverse Drug Reaction Newsletter. These programs cost money and require a continued commitment. The regional centres struggle on paltry budgets to provide minimal service, the expert advisory committee has been all but abandoned and the use of high-quality provincial health databases is beyond the program's financial reach. Evidently, Health Canada does not understand that drug-induced illness is a major public health concern.

Setting up proactive surveillance programs would be a worthwhile endeavour in any country.[6] The New Zealand Intensive Medicines Monitoring Program[7] is a good example of what can be done at a reasonable cost. Health Canada would do well to explore this option once it decides to support pharmacovigilance in our country.

W.C. Appel
Principal
Kusuri Canada Corp.
Ottawa, Ont.

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Clinicians' role in responding to bullying

I read with great interest Erica Weir's Public Health article on the potentially harmful impact of bullying on victims' psychosocial adjustment.[1] As a high percentage of children and adolescents are exposed to bullying without adequate intervention from school personnel, parents or mental health professionals,[2] I was particularly pleased to read Weir's discussion about the role of clinicians in responding to peer victimization.

In addition to enhancing the self-esteem of the victim, psychotherapy can address the contribution of psychiatric symptomatology, namely difficulties with social anxiety, to problematic peer relationships. Socially anxious people typically experience cognitive, behavioural and physiological symptoms in anticipation of or during social interactions. Such symptoms are often associated with difficulty in peer relations, as overt anxiousness may interfere with the development of social skills and friendships.[3] In addition, the overt anxiety displayed by some victims may make them vulnerable to peer maltreatment because they present easy targets to bullies.[4]

Eric A. Storch
Department of Clinical Psychology
Teachers College
Columbia University
New York, NY

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Air travel and venous thromboembolism — the jury is still out

Recent correspondence by Michael Mant states that the association between air travel and venous thromboembolism is weak.[1] However, more evidence has appeared in the literature in the last few months on this association. A recent study found that distance travelled is a significant contributing risk factor for pulmonary embolism associated with air travel.[2] In this study, the rate of pulmonary embolism was 4.8 cases per 1 000 000 passengers for those travelling more than 10 000 km, and 1.5 cases per 1 000 000 for 5000 km of travel, as compared to 0.01 cases per 1 000 000 among those travelling less than 5000 km.

Symptomless deep vein thrombosis (DVT) might occur in up to 10% of long-haul airline travellers, and the wearing of elastic compression stockings during long-haul air travel is associated with a reduction in symptomless deep vein thrombosis.[3]

A report from the House of Lords in the United Kingdom entitled *Fifth Report: Air Travel and Health* has reviewed the evidence available and put forward certain recommendations to prevent deep vein thrombosis based on the baseline risk of the passengers.[4]

Finally, information for air travellers on ways to prevent venous thromboembolism is abundant on the Internet. The Web site www.airhealth.org has produced an excellent information sheet.[5] Travellers can print it off and carry it with them. Some interesting tips on in-flight exercises can also be found from the Web site of Qantas.[6]

The jury is still out on this association, and we can expect a verdict as more high-quality evidence emerges in the literature.

Padmanabhan Badrinath
Clinical Assistant Professor &
Epidemiologist
Faculty of Medicine & Health Sciences
UAE University
Al-Ain, United Arab Emirates

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