

causing immeasurable harm to excellent practitioners. This encourages witch hunts and little else. Unfortunately, we do not live in a fair and just society. It is naive to believe that all public and medical administrators have the best interests of departmental practitioners in mind. Too many personal vendettas are carried out by people in positions of responsibility using imprecise data.

Other methods are available that do not require publicly disclosing imprecise information to a public that lacks the degree of sophistication required to understand it.

In addition, the editors of *CMAJ* are guilty of misusing their position by threatening not to give equal access to publication of quality work — simply because institutional identities are withheld. Is it not better to know a problem exists (or not) than to have no idea at all? This kind of arrogant superiority is likely to stifle knowledge acquisition and encourage misuse of imprecise information.

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Reference

1. Hoey J, Todkill AM, Flegel K. What's in a name? Reporting data from public institutions [editorial]. *CMAJ* 2002;166(2):193-4.

Smallpox still poses a threat

Although Erica Weir's recent public health article on smallpox is very informative, it does not actually answer the question posed in the title: Does smallpox still pose a threat?¹ As long as there are stockpiles of smallpox in the world, it poses a real, if small, threat. Smallpox could be released into the population as a result of a bioterrorist attack or if one person with access to the stockpile becomes mentally unstable and decides to release the virus. One syringe of this pathogen released into a crowded subway would be sufficient to

produce several cases of smallpox. Failure to contain even one of these cases could lead to a chain reaction.

I am particularly concerned about the well-being of our first responders. Nurses and physicians under 30 years of age have not been vaccinated. Although protective clothing would provide some protection, it would not be fail-safe. In addition, medical staff might use limited barrier precautions while treating patients with difficult-to-diagnose forms of smallpox until the diagnosis is made.²

We require a strategic plan to contain smallpox that would ensure the protection of front-line workers. There is also a need for more widespread vaccination, possibly with a re-engineered vaccine that has the necessary epitopes to protect without producing toxicity.

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References

1. Weir E. Does smallpox still pose a threat? *CMAJ* 2001;165(10):1380.
2. Henderson D, Inglesby T, Bartlett J, Ascher M, Eitzen E, Jahrling P, et al. Smallpox as a biological weapon: medical and public health management. *JAMA* 1999;281:2127-37.

[The author responds:]

I thank Roslyn Devlin for moving the dialogue on smallpox beyond rhetoric by advocating for the safety of our first responders and calling for a strategic plan.

Erica Weir

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Saskatchewan continues breast cancer screening

Your recent article on gene patenting and breast cancer screening stated incorrectly that Saskatchewan did not provide these genetic-sequencing tests.¹ Saskatchewan is continuing

to offer genetic testing for both the *BRCA1* and *BRCA2* genes to its residents. Because we do not have a local testing facility, we have been sending our DNA samples to a clinical lab in Ottawa since about 1998.

Because Ontario is challenging the matter in court, we have been able to continue providing this service. This is an important point because there is very high demand for this service and we want Saskatchewan physicians to be appropriately informed so that they do not mislead patients who ask about this.

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Reference

1. Eggertson L. Ontario defies US firm's genetic patent, continues cancer screening. *CMAJ* 2002; 166(4):494.

Measles vaccine dosage

In a public health piece on measles, Howard Shapiro and Erica Weir state "The second dose [of measles vaccine or measles, mumps and rubella vaccine] should be given at least 3 months after the first."¹ I have reviewed all of the references listed for the article and each one clearly states that the second dose should be given at least 1 month (minimum 28 days) after the first.

Judith Almond-Best

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Reference

1. Shapiro H, Weir E. Measles in your office. *CMAJ* 2001;164(11):1614.

[One of the authors responds:]

Judith Almond-Best is right. The second dose of measles can be given at least 1 month (minimum 28 days) after the first. Somehow in the many versions of the article before