deterioration of 5.6% seen in Naglie and colleagues' trial. Equally, among stroke patients, roving stroke units are probably less effective than geographically focused units.[3] Perhaps the physical centralization of geriatric hip-fracture patients is similarly important.

It is still unknown in definitive terms why stroke units are effective. Common sense gives us reasons but, broadly speaking, perhaps focused multidisciplinary care could improve outcomes for relatively homogeneous patient populations in a wide range of disciplines. It would be worth while to pursue a larger multicentre study of interdisciplinary hip-fracture care with sufficient power to detect small benefits. A 5% absolute benefit would be clinically important in Canada, with obvious relevance as the population ages.

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3. Evans A, Harraf F, Donaldson N, Kalra L. Randomized controlled study of stroke unit care versus stroke team care in different stroke subtypes. *Stroke* 2002;33:449-55.

[Four of the authors respond:]

We thank Michael Hill for his comments and agree that our study[1] may have missed a clinically important difference because of a lack of statistical power. As we stated in our interpretation, the 95% confidence interval for the primary outcome measure (–5.6% to 17.0%) allowed for the possibility of a clinically important effect. We strongly support the need for a larger multicentre trial to study the effectiveness of interdisciplinary care for elderly people with hip fracture. However, as we stated in our paper, we recommend that the intervention be targeted to a subgroup of patients that may be more likely to benefit than the heterogeneous population included in our study.

Hill writes of the potential importance of physically centralizing geriatric hip-fracture patients, as is done with stroke patients. In our study, the intervention patients were located together in the hospital.

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University Health Network
Ed Etchells
Sunnybrook and Women's College Health Sciences Centre
George Tomlinson
University Health Network
University of Toronto
Toronto, Ont.

Reference
1. Naglie G, Tansey C, Kirkland JL, Ogilvie-Harris DJ, Detsky AS, Etchells E, et al. Interdiscipli-

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Disclosure at Pfizer Canada

In a recent letter to the editor,[1] Joel Lexchin discusses the results of his requests for published clinical information from 12 Canadian pharmaceutical companies. Pfizer Canada Inc. received a written request from Lexchin for a list of all randomized, controlled, fully published clinical trials regarding the use of sildenafil for treatment of erectile dysfunction published in English at the time the product was first marketed in Canada. On Sept. 24, 2001, we provided Lexchin with a list of the requested sildenafil studies. We were therefore surprised not to be mentioned by Lexchin as one of the companies who provided complete and accurate information.

Pfizer Canada is committed to an open dialogue with the Canadian health care community. We welcome criticism as an opportunity to improve the quality of our services. We therefore would like to understand why our response to Lexchin did not meet his expectations.

Bernard M. Prigent
Vice President and Medical Director
Pfizer Canada Inc.
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Reference

1. Lexchin J. Inaccessibility of drug reports [letter]. *CMAJ* 2002;166(10):1251.

[The author responds:]

Pfizer Canada Inc. responded to my initial request[1] 1 month after it was mailed. Three other companies replied more rapidly, but most took longer than Pfizer Canada; relatively speaking, Pfizer Canada's response was prompt. In its response, Pfizer Canada did list all of the relevant trials, but 3 additional papers were listed that did not fulfil the criteria in my request. One was an uncontrolled nonblinded trial,[2] the second was a retrospective subanalysis of data from double-blind, placebo-controlled studies[3] and the third analyzed safety and tolerability data from a series of double-blind, placebo-controlled studies and open-label extension studies.[4]

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