Advertisement woes

The March 29, 2005, issue of *CMAJ* carries a full-page advertisement for Hydromorph Contin on page 848. The advertisement states that "some patients may also experience fewer side effects than with morphine...", and this statement cites two 2 references.[1,2] In fact, the two 2 articles cited do not make this claim, or even suggest it as far as I can see. The first citation does not contain the word "hydromorphone" anywhere in the text, and neither article mentions the specific product being advertised.

It is hard for me to escape the conclusion that the advertiser knowingly sought to mislead *CMAJ*'s readers by citing this work in the hope that no-one would check the facts. That I did so in this case is merely a function of the implausibility of the claim and my interest in the area.

CMAJ is an authoritative voice in Canadian medicine. I suggest that greater steps need to be taken to ensure that every word of every advertisement in it is verifiably truthful. This is too important to be left to the advertisers themselves.

Saifee Rashiq
Associate Professor
Director
Division of Pain Medicine
Department of Anaesthesiology
and Pain Medicine
University of Alberta
Edmonton Alta.

Competing interests: I have given lectures on pain management and opioid use under the sponsorship of Purdue Pharma and have also been compensated for the recruitment of subjects for their trials of opioid analgesics.

REFERENCES

1. Portenoy RK, Coyle N. Controversies in the long-term management of analgesic therapy in patients with advanced cancer. *J Pain Symptom Manage* 1990;5(5):307-19.
2. de Stoutz ND, Bruera E, Suarez-Almazor M. Opioid rotation for toxicity reduction in terminal cancer patients. *J Pain Symptom Manage* 1995;10(5): 378-84.

DOI:10.1503/cmaj.1050130

[The PAAB commissioner responds:]

The Pharmaceutical Advertising Advisory Board (PAAB) has a submission review process and a complaint resolution process. Both can be seen in the PAAB Code of Advertising Acceptance at www.paab.ca. If Dr. Rashiq wants to register an official complaint he can contact me directly about the process. The complaint resolution process includes an opportunity for the sponsor, in this case Purdue Frederick, to address the allegations. The PAAB Commissioner has to honour the process that has been agreed to by the PAAB voting members, and that includes the CMA.

Dr. Rashiq's complaint may have merit. I did a brief check of our files and I note that the references have been used in advertising as far back as 1997, two years before I became Commissioner. We have received no other complaints about that particular claim. The complaint resolution process would require a re-analysis of the use of these articles to support the claim in the ad. If Dr. Rashiq wants to know who looks at advertising, the PAAB has reviewed over 20 000 new advertising pieces since 1997, with few substantiated complaints.

Ray Chepesiuk
PAAB Commissioner
Mississauga, Ont.

DOI:10.1503/cmaj.1050239

[The advertiser responds:]

The statement criticized by Dr. Rashiq ("some patients may also experience fewer side effects than with morphine") is fully consistent with the literature on opioid rotation that has become available over the past 15 years.

Portenoy and Coyle[1] were among the first to comment on individual patient variability in opioid response, and an early report by Galer and colleagues[2] described the management of inadequate therapeutic response to and severe adverse effects from morphine, by switching to alternate opioids — including hydromorphone.

The other cited paper[3] describes 191 patients in the Palliative Care Unit at Edmonton General Hospital, of whom 42% required a switch in opioid because of serious toxicity or inadequate analgesia. The most frequently used initial and alternative opioids were morphine and hydromorphone, respectively. Improvement in both pain levels and the primary symptom necessitating a change in opioid, occurred on conversion from morphine to hydromorphone (or other opioids).

Later studies, also published by the University of Alberta group,[4,5] further discuss the clinical role of opioid rotation, including the equianalgesic dose ratios for switching between morphine and hydromorphone.

Recently, Nauck and colleagues[6] reported on a series of patients who showed improvements in pain control and side effects when switched from morphine to controlled-release hydromorphone.

An interesting case of differential response to morphine and hydromorphone was described by Katcher and Walsh.[7] Uncontrollable itching on morphine (an infrequent side effect attributed to cutaneous histamine release) fully resolved within 24 hours of conversion to hydromorphone.

The mechanisms underlying a dif-

ferential response to hydromorphone and morphine are not established, but possibilities include: differences in metabolism — hydromorphone is metabolized primarily to hydromorphone-3-glucuronide and, unlike morphine, does not form a 6-glucuronide metabolite that has opioid activity;[8] incomplete cross-tolerance; or as yet uncharacterized differences in opioid receptor subtype activity.

We believe that the clinical evidence for individual differences in opioid response, recently summarized in a comprehensive review of hydromorphone from the Cleveland Clinic,[9] fully supports the accuracy of the statement in the advertisement criticized by Dr. Rashiq.

George Vautour
Director
Analgesic Product Group
Purdue Pharma
Pickering, Ont.

REFERENCES

1. Portenoy RK, Coyle NJ. Controversies in the long-term management of analgesic therapy in patients with advanced cancer. *Pain Symptom Manage* 1990;5(5):307-19.
2. Galer BS, Coyle N, Pasternak GW, et al. Individual variability in the response to different opioids: report of five cases. *Pain* 1992;49(1):87-91.
3. de Stoutz ND, Bruera E, Suarez-Almazor M. Opioid rotation for toxicity reduction in terminal cancer patients. *J Pain Symptom Manage* 1995;10(5):378-84.
4. Bruera E, Pereira J, Watanabe S, et al. Opioid rotation in patients with cancer pain. A retrospective comparison of dose ratios between methadone, hydromorphone, and morphine. *Cancer* 1996;78(4):852-7.
5. Bruera E, Franco JJ, Maltoni M, et al. Changing pattern of agitated impaired mental status in patients with advanced cancer: association with cognitive monitoring, hydration, and opioid rotation. *J Pain Symptom Manage* 1995;10(4):287-91.
6. Nauck F, Ostgathe C, Dickerson ED, et al. Controlled release hydromorphine: an alternative to morphine for cancer pain. *The Pain Clinic* 2002;2:13-6.
7. Katcher J, Walsh D. Opioid-induced itching: morphine sulfate and hydromorphone hydrochloride. *J Pain Symptom Manage* 1999;17(1):70-2.
8. Zheng M, McErlane KM, Ong MC. Hydromorphone metabolites: isolation and identification from pooled urine samples of a cancer patient. *Xenobiotica* 2002;32(5):427-39.
9. Sarhill N, Walsh D, Nelson KA. Hydromorphone: pharmacology and clinical applications in cancer patients. *Support Care Cancer* 2001;9(2):84-96.

DOI:10.1503/cmaj.1050240

Wait times affect kids too

We are pleased that Dr. Brian Postl has been named the new Federal Advisor on Wait Times.[1] Despite a mandate prescribed by the First Ministers' Health Accord of 2004 to concentrate on five key areas (heart, cancer, diagnostic imaging, joint replacement and sight restoration), we hope that Dr. Postl's experience as a pediatrician will give him insight into a 6th key area: children's surgical wait times. Children rarely need heart revascularization, cataract surgery or hip replacements, but they may need surgery for serious birth defects, cancer, traumatic injuries and a variety of other conditions, ranging from minor to life-threatening. In BC, we have compared our wait times for children's surgery with those suggested by our professional organizations and have found that only 35% of BC children undergoing elective surgery did so within recommended wait times. Among children requiring cancer surgery, only 38% had operations during weekday working hours.[2] From this we conclude that the combination of deferred elective surgery and increased out of hours emergent or urgent (cancer) surgery are the adjustments necessary to enable timely surgical treatment for children of BC. Neither approach is safe or sustainable.

The Pediatric Surgical Chiefs of Canada believe that there is much to be done for children's surgical care delivery in Canada: let's set national "benchmarks" for children's waiting times and monitor our performance.

Geoffrey K. Blair
Chief of Surgery
British Columbia's Children's Hospital
On behalf of the Pediatric Surgical Chiefs of Canada
Vancouver, BC

REFERENCES

1. Eggertson L. Wait Time Alliance first to set benchmarks. *CMAJ* 2005;172(10):1277.
2. Reebye SC, Blair GK, Rogers PC, et al. An audit of cancer diagnosis in a Canadian children's hospital: quality, timing and efficiency. *Pediatr Child Health*. In press.

Competing interests: None declared.

DOI:10.1503/cmaj.1050182

Medical care delivery

As an admirer of the invariably high standards of *CMAJ*'s lead editorials, I would like to record a small comment about the one on monitoring the quality of medical care delivery.[1] A hospital admission is frightening enough for patients, without their learning from an authoritative source that hospitals "are particularly dangerous places" and that "the overall incidence rate of adverse events that result in death, disability or prolonged hospital stay in Canadian hospitals is 7.5 per 100 hospital admissions." From this, the trembling patient would reasonably assume that 7.5% of admissions can be expected to result in one of these fearful outcomes. However, the source article for this statistic tells us that nearly one-third of these events occurred in the 12 months preceding the index hospital admission. Thus, the rate of adverse events occurring during a hospital stay was closer to 5.2%.[2]

Doctors and patients are well aware that few therapies have a 100% success rate and that perfectly appropriate treatment can be associated with unwanted outcomes. The figure we all need to know is the rate of preventable adverse events. In the study by Baker and colleagues this was 2.8%.[2] We also need to know whether the consequences of these events are really "death, disability or prolonged hospital stay." Some proportion of adverse events in the study probably resulted only in slight extensions of the patient's stay in hospital; most (56%) resulted in no impairment, minimal impairment or impairment with recovery within 1 month.[2] The 7.5% figure cited in the editorial is barely relevant and unnecessarily frightening.

Maurice McGregor
McGill University Health Centre
Montréal, Que.

REFERENCES

1. Disclosure and performance: expecting more, and better [editorial]. *CMAJ* 2005;173(5):457.
2. Baker GR, Norton PG, Flintoft V, Bet al. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ* 2004;170(11):1678-86.

DOI:10.1503/cmaj.1050188

A recent *CMAJ* lead editorial notes that failures to manage patients according to widely accepted standards of care may be more common than the medical errors that result in serious adverse events in Canadian hospitals.[1] The editorial goes on to suggest that "process-of-care standards could be implemented in hospital and ambulatory practice; adherence could be monitored and the results disclosed."[1]

In BC we have established many standards of care through our clinical practice guidelines and we monitor adherence to many of them through administrative data. We can easily confirm your suspicion concerning the prevalence of failures to manage patients according to accepted standards of care.[2]

I am dismayed that you feel that public disclosure of the results of such monitoring will push physicians to improve their scores. This approach is rooted in the culture of blame that bedevils our health system and that so often leads to selective reporting, gaming, concealment and lack of cooperation with otherwise promising quality improvement initiatives. Measurement should be for learning, not for judgment. In BC we offer software that provides doctors with their performance measures in the privacy of their own office. I believe this creates a safe environment where doctors can learn to improve the care they provide and that making the results public would detract from this process.

G. Howard Platt
Director
Medical Outcomes Improvement Branch
British Columbia Ministry of Health
Victoria, BC

REFERENCES

1. Disclosure and performance: expecting more, and better [editorial]. *CMAJ* 2005;173(5):457.
2. People with diabetes and proportion receiving recommended services by age and gender, British Columbia, 2002/2003. Victoria: British Columbia Ministry of Health Services; 2004. Available: www.healthservices.gov.bc.ca/cdm/research/diabetes_rec_servs_agegender_02-03.pdf (accessed 2005 Oct 14).

DOI:10.1503/cmaj.1050196

Female genital mutilation

Shame on *CMAJ* for using the term "female circumcision."[1] More than a decade ago, the UN seminar on Traditional Practices Affecting the Health of Women and Children (Burkino Faso, 1991) recommended that the term "female genital mutilation" be used instead.[2]

The word "circumcision" downplays the appalling nature and consequences of female genital mutiltation. The WHO states that "excision of the clitoris and labia minor ... are the commonest types of female genital mutilation. They constitute up to 80% of all female genital mutilation practised."[2] It is obvious that female genital mutilation and male circumcision are not analogous. Use of the term "female circumcision" obscures the issue and does a disservice to your readers and to all girls and women.

Phillipa Rispin
Medical Writer–Editor
Montréal, Que.

REFERENCES

1. Lang MA, Darwish A, Long AM. Vaginal bleeding in the prepubertal child. *CMAJ* 2005;172(10):1289-90.
2. Gender and Women's Health Department, World Health Organization. Female genital mutilation: information pack [Web site]. Available: www.who.int/docstore/frh-whd/FGM/infopack/English/fgm_infopack.htm (accessed 2005 Nov 7).

DOI:10.1503/cmaj.1050118

[The author responds:]

Phillipa Rispin is correct that the United Nations has recommended the term "female genital mutilation (FGM)" rather than "female circumcision"; however, as the editors point out, some people would feel insulted by the term "mutilation." In the case we described,[1] the parents clearly used the term "circumcision" rather than "mutilation" in describing their daughter's medical history. I agree that "female circumcision" is not analogous to male circumcision, and Box 1 in our article clearly describes what can be involved in FGM. As health care professionals, it is important to be culturally sensitive, while at the same time being aware of health practices that can potentially harm our patients and educate families accordingly.

Mia E. Lang
Assitant Professor
Pediatrics
University of Alberta
Edmonton, Alta.

REFERENCE

1. Lang MA, Darwish A, Long AM. Vaginal bleeding in the prepubertal child. *CMAJ* 2005;172(10):1289-90.

DOI:10.1503/cmaj.1050187

[The senior deputy editor responds:]

We thank Phillipa Rispin for drawing this to our attention and agree that the term "female circumcision" is an inappropriate euphemism. However, some clinical practice guidelines have pointed out that not all women who have undergone genital modification in its various forms consider themselves mutilated and may be insulted by the term "female genital mutilation."[1] Terms such as "traditional female surgery," "ritual female surgery" and "female genital cutting" have been proposed by some groups as nonjudgmental alternatives. However, in view of the serious harms associated with these practices and the disempowerment of the majority of girls and young women who are affected, we defer to the WHO's recommendation and have adopted "female genital mutilation (FGM)" as the preferred term in our style guide. Canadian physicians should bear in mind, however, that while FGM is not legal in this country, the terms they use in discussing this practice and its consequences with patients need to be culturally sensitive.

Anne Marie Todkill
CMAJ

REFERENCE

1. Female genital mutilation [clinical practice guideline]. Melbourne, Australia: Royal Women's Hospital. Available: www.rwh.org.au/rwhcpg/womenshealth.cfm?doc_id=4343 (accessed 2005 Nov 7).

DOI:10.1503/cmaj.1050166

Giant cell arteritis

Renatta Varma and Anil Patel remind us of the variability in presentation of giant cell arteritis (GCA).[1] Another patient's story presents yet another pitfall in GCA diagnosis.

A 76-year-old woman presented to the emergency department with right temporal "head pain." Her erythrocyte sedimentation rate was 65 mm/h. The diagnosis was "headache, rule out temporal arteritis." Prednisone, 40 mg per day, was prescribed, and the patient was referred for follow-up examination. Four days later, the patient's tenderness to percussion over the right temporal area persisted, and I increased the prednisone dosage. A biopsy was performed 2 days later.

The biopsy results, available 1 week later, showed no evidence of GCA, so the ophthalmologic surgeon stopped the patient's prednisone. The patient returned to me 4 days later with increasing "head pain." We discussed the possibility of false-negative biopsy findings, and I prescribed prednisone again (and osteoporosis prophylaxis). A consultation was arranged with a rheumatologist who concurred with the diagnosis of biopsy-negative CGA and continued to treat the patient accordingly.

Although the only confirmatory test for GCA is a positive biopsy, nondiagnostic biopsy specimens do not exclude the diagnosis. It is commonly accepted that, because of the patchy involvement of the arteries, biopsies may be nondiagnostic in many patients. Thus, because biopsies are invasive, some authors even suggest that biopsy may not be necessary.[2,3]

Furthermore, corticosteroid therapy, which should be started without delay, rapidly reduces the chance of a positive biopsy result.[2] One week of corticosteroid treatment may reduce the chance of obtaining a positive biopsy to 10%.[4] Therefore, biopsy should be performed within the first few days of therapy.[4]

Gary N. Fox
Defiance Clinic
Toledo, Ohio

REFERENCES

1. Varma R, Patel AD. Scalp lesions in a 78-year-old woman. *CMAJ* 2005;173(1):33.
2. Swannell AJ. Polymyalgia rheumatica and temporal arteritis: diagnosis and management. *BMJ* 1997; 314:1329-32.
3. Caselli RJ, Hunder GG. Giant cell (temporal) arteritis. *Neurol Clin* 1997;15:893-902.
4. Pountain G, Hazleman B. ABC of rheumatology. Polymyalgia rheumatica and giant cell arteritis. *BMJ* 1995;310:1057-9.

Competing interests: None declared.

DOI:10.1503/cmaj.1050155

Renatta Varma and Anil Patel recently discussed herpes zoster (*varicella* zoster virus) infection as a differential diagnosis of GCA.[1] Interestingly, 88% of arteries with histologically confirmed GCA have been found to harbour herpes simplex virus DNA.[2] Consideration of both herpes zoster and herpes simplex as a cause in this case of necrotic scalp lesions may therefore be warranted.

Heike Varnholt
Department of Pathology
Baystate Medical Center
Springfield, Mass.

REFERENCES

1. Varma R, Patel AD. Scalp lesions in a 78-year-old woman. *CMAJ* 2005;173(1):33.
2. Powers JF, Bedri S, Hussein S, et al. High prevalence of herpes simplex virus DNA in temporal arteritis biopsy specimens. *Am J Clin Pathol* 2005;123:261-4.

DOI:10.1503/cmaj.1050160

[The authors respond:]

We concur with Gary Fox that if the clinical suspicion of GCA is high this condition should still be considered even if the biopsy results are nondiagnostic, especially because of its potential to cause devastating bilateral and irreversible blindness.[1] However, we would caution against diagnosing giant cell arteritis without biopsy evidence (biopsy-negative GCA) because of the potential detrimental side effects of long-term steroid use.

Skip lesions are possible,[2,3] but we find it useful to obtain a biopsy specimen at least 2–3 cm long and to ensure that the pathologist serially examines the entire length of the specimen. If clinical suspicion remains despite a negative unilateral biopsy, then we recommend a contralateral biopsy as soon as possible, regardless of the time that has elapsed. Although steroid administration can affect a biopsy result, we have had numerous patients for whom a biopsy result was positive even after several weeks or months of steroid therapy. Furthermore, we consider temporal artery biopsy to be a relatively safe and simple office procedure. If 2 temporal artery biopsies are negative for GCA, we consult an internist to evaluate the patient's erythrocyte sedimentation rate or C-reactive protein level, or both, to search for a systemic infection or malignancy.

Anil D. Patel
Clinical Associate Professor
Dean A. McGee Eye Institute
Oklahoma City, Okla.
Renatta Varma
Fellow
Vitreoretinal Surgery
Victoria, BC

REFERENCES

1. Hayreh SS, Podhajsky PA, Zimmerman B. Ocular manifestations of giant cell arteritis. *Am J Ophthalmol* 1998;125:509-20.
2. Klein RG, Campbell RJ, Hunder GG, et al. Skip lesions in temporal arteritis. *Mayo Clin Proc* 1976; 51:504-10.
3. Albert DM, Ruchman MC, Keltner JL. Skip areas in temporal arteritis. *Arch Ophthalmol* 1976;94:2072-7.

DOI:10.1503/cmaj.1050197

Corrections

The DOIs for a recent commentary[1] and a recent review article[2] should have read 10.1503/cmaj.051291 and 10.1503/cmaj.050141, respectively.

REFERENCES

1. Knoll G, Cockfield S, Blydt-Hansen T, et al, for the Kidney Transplant Working Group of the Canadian Society of Transplantation. Canadian Society of Transplantation consensus guidelines on eligibility for kidney transplantation *CMAJ* 2005;173 (10):1181-4.
2. Babuin L, Jaffe AS. Troponin: the biomarker of choice for the detection of cardiac injury. *CMAJ* 2005;173(10):1191-202.

DOI:10.1503/cmaj.051428