

Newman accurately pointed out some difficulties in interpreting our data. There is no doubt that data collected through surveillance programs can be incomplete because of the nature of these programs, and this can lead to an underestimation of the number of cases and can limit our ability to thoroughly analyze the factors underlying the findings. Despite this limitation, our study has shown that severe hyperbilirubinemia continues to occur in Canada. The majority of the infants with severe hyperbilirubinemia in our study were readmitted shortly after leaving the hospital, raising the concern that health care providers are missing an opportunity to prevent this condition. Although recommendations from the American Academy of Pediatrics³ were recently published, they are currently not being followed or are impractical to apply to newborns.

Given the possibility that introducing routine screening (serum bilirubin measurements, blood group typing and Coombs' testing) may have financial implications such as longer hospital stays for newborns, it is important to understand the burden of illness of severe hyperbilirubinemia and its complications in Canada, namely bilirubin-induced neurological dysfunction and kernicterus. Newman and Maisels referenced a Danish case-based report⁴ that estimated the incidence of kernicterus at 1 in 50 000 to 1 in 60 000 live births. It is important to note that this was by no means a systematic review of the Danish population. In our study, half of the infants with severe hyperbilirubinemia were born to non-white mothers.² Ethnicity may be a contributing factor to severe hyperbilirubinemia, secondary to a higher incidence of glucose-6-phosphate dehydrogenase deficiency in non-white populations and a delay in recognition of jaundice owing to the babies' darker pigmentation.

We believe that careful assessment of newborns at the time of discharge and consideration of blood group incompatibility and risk of glucose-6-

phosphate dehydrogenase deficiency with appropriate follow-up could reduce the incidence of neonatal hyperbilirubinemia and readmission to hospital. A more accurate estimate of the incidence of kernicterus is of paramount importance in order to justify cord blood testing and the measurement of serum bilirubin at the time an infant is discharged from hospital.

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REFERENCES

1. Maisels MJ, Newman TB. Surveillance of severe neonatal hyperbilirubinemia: a view from south of the border. *CMAJ* 2006;175(6):599-600.
2. Sgro M, Campbell DM, Shah V. Incidence and causes of severe neonatal hyperbilirubinemia in Canada. *CMAJ* 2006;175(6):587-90.
3. American Academy of Pediatrics. Clinical practice guideline: management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics* 2004;114(1):297-316.
4. Ebbesen F. Recurrence of kernicterus in term and near-term infants in Denmark. *Acta Paediatr* 2000; 89(10):1213-7.

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Corrections

In the meta-analysis of β -blockers for the treatment of hypertension by Nadia Khan and Finlay McAlister,¹ there were typographic errors in the numbers reported on the right-hand side of Figs.

2A and 2B. None of the typographic errors were incorporated in the analyses, and thus there was no effect on the findings or interpretation of the findings. The corrections are summarized here.

Fig. 2A: For the Medical Research Council trial, the denominator for "other drug" should read 4297 (instead of 8654). The overall denominator was 14 708 for the β -blocker group and 14 638 for the "other drug" group.

Fig. 2B: The overall denominator was 42 598 for the β -blocker group and 44 582 for the "other drug" group. The *p* value for heterogeneity should be 0.08, not 0.8. The pooled summary estimate was 1.07 (95% CI 1.00–1.14).

REFERENCE

1. Khan N, McAlister FA. Re-examining the efficacy of β -blockers for the treatment of hypertension: a meta-analysis. *CMAJ* 2006;174(12):1737-42.

DOI:10.1503/cmaj.070283

A recent News article¹ concerning the amount of money Canada spends on foreign aid contained some typographical errors. In fact, Canada spent \$2.719 billion on international aid in 2003/04. This was raised to \$3.237 billion in 2005. In 2005/06, the federal government spent \$3.637 billion. We apologize for any inconvenience this error may have caused.

REFERENCE

1. Kondro W. International aid doldrums. *CMAJ* 2007;176(1):26.

DOI:10.1503/cmaj.070284

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