

of pulmonary capillary wedge pressure ("congestion") is not necessarily equivalent to volume overload. However, it is our understanding that the vast majority of patients in this situation do have total body volume overload, as evidenced by edema, increased venous filling pressures and hemodilution.²⁻⁵ From our clinical experience we would argue for some form of volume reduction therapy as part of the overall treatment strategy for most patients presenting with worsened heart failure and signs of congestion. Few clinicians would dispute that removing fluid from such patients makes them feel better. To further study these issues, we are participating in the development of a randomized trial sponsored by the National Institutes of Health Heart Failure Network in which low and high doses of furosemide will be compared in the treatment of acute decompensated heart failure.

The dose conversions for sublingual to intravenous nitroglycerin provided by Howard Smithline are very helpful. Patients with marked hypertension who tolerate sublingual nitroglycerin may certainly be started at relatively higher doses than we recommended in our article. However, the effect of a single dose of sublingual nitroglycerin is typically short-lived, so direct comparison with a continuous infusion of nitroglycerin may not be appropriate. Hypotension is problematic in the management of such patients and consequently we use a conservative approach, starting with a relatively low dose of intravenous nitroglycerin that is then titrated upward rapidly as tolerated by the patient, as evidenced by hemodynamic measurements and symptoms.

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Competing interests: None declared for Dr. Allen. Dr. O'Connor has acted as a consultant to and has received speaker fees from Pfizer, Glaxo-SmithKline, Medtronic and NitroMed.

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DOI:10.1503/cmaj.1070063

Eating well

The criticism levelled at *Eating Well with Canada's Food Guide*¹ in a recent *CMAJ* news piece² does not take into account the evidence that underpins the recommendations in the guide nor the extensive consultation process that preceded its writing. In particular, the comment that the food guide is "obesogenic"² is unwarranted.

The eating pattern recommended in the guide was developed using an extensive modelling process to ensure that it met nutrient standards and energy recommendations (dietary reference intakes) and was consistent with evidence linking food with the risk of developing certain chronic diseases. Health Canada consulted extensively with consumers, health professionals and food industry representatives and sought advice from 3 expert panels that included dietitians. It is noteworthy that feedback received from testing the guide with focus groups of consumers and health intermediaries (such as teachers, physicians, primary care nurses, home economists and fitness specialists who play a role in disseminating nutrition guidelines to consumers) did not support the inclusion of information about calories. Rather, the focus groups recommended strengthening the messages that provide practical advice on the types of foods to choose and those to limit and including messages on physical activity. The number of calories any one person needs can only be calculated after careful consideration, in consultation with a registered dietitian.

Focusing on calorie counting alone can result in very unhealthy dietary practices.

Eating Well with Canada's Food Guide is a fundamental tool for health educators, but it cannot be expected to meet all educational needs. It is not designed to provide a weight-loss regimen; rather, it promotes a pattern of healthy eating and daily physical activity over a lifetime.

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DOI:10.1503/cmaj.1070058

Access to the medical literature

We fully agree with Brad MacKay¹ that nationwide access to the Cochrane Library is a priority, especially because only 10%–15% of Canadians, mostly medical students and academic researchers, currently have access to this resource. However, Canadian physicians, health care professionals and the public need more than access to just the Cochrane Library; they need coordinated access to all electronic health information resources (including databases, journals and books) as well as user training and support.² The Canadian Health Libraries Association has been championing a National Network of Libraries for Health, the vision of which is to "ensure that all health care providers in Canada will have equal access to the best information for patient care."³ Canadian health libraries would handle national coordination of access, training and support.

In 2006, Sir Muir Gray was knighted for his work, including the development of the National Library for Health in the United Kingdom. In a *CMAJ* guest editorial published last year, he stated that it

has always seemed paradoxical that Canada, a country that is the fount of so much good work in evidence-based medicine and knowledge translation, does not have a national health library.⁴

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Competing interests: Jessie McGowan and Patrick Ellis are co-chairs of the National Network of Libraries for Health Task Force.

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DOI:10.1503/cmaj.107002

Macrolide resistance in streptococcal pharyngitis

The infectious disease specialists in our hospital recently noticed increasing rates of complications in immunocom-

petent adults and children with streptococcal pharyngitis, secondary to treatment failure. Complications such as postpharyngitis erysipelas, retropharyngeal abscesses and sinusitis were all found to be associated with 1 factor: resistance to treatment with a macrolide (azithromycin) and a lincosamide (clindamycin).

We evaluated the epidemiology of resistance to erythromycin and clindamycin in group A *Streptococcus* in the population served by our hospital. During December 2006, 101 consecutive isolates of group A *Streptococcus* recovered from throat swab specimens (1 per patient) were tested in our microbiology laboratory by disk diffusion.¹ We found that 42.6% of the isolates were resistant to erythromycin and 39.6% to clindamycin, rates that are among the highest ever published.

Many previous studies have shown that the rate of resistance to a specific antibiotic is proportionally related to its use. The rate of prescription of azithromycin in New Brunswick is 2–3 times the Canadian mean, according to IMS Canada data made available to us by the Canadian Integrated Program for Antimicrobial Resistance Surveillance of the Public Health Agency of Canada through their antibiotic use database. This underlines the importance of following well-known but unfortunately neglected antibiotic guidelines. First, antibiotics should be prescribed only to treat obvious bacterial infections and only when an antigen-detection test or a culture or both are positive. Second, macrolides are considered to be a third-line therapy for streptococcal pharyngitis and their use should be limited accordingly. Penicillin V remains the

treatment of choice and should be replaced by cephalosporins if the patient has a nonanaphylactic allergy to penicillin. Finally, if a macrolide must be used to treat streptococcal pharyngitis, its group A *Streptococcus* strain susceptibility should be tested on the specimen sent for throat culture to avoid clinical or microbiological treatment failure.

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Competing interests: None declared

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DOI:10.1503/cmaj.107000

Correction

A recent story¹ about the sale of the Sir Frederick Banting homestead that appeared in the News section should have stated that the 100-acre farm was bequeathed to the Ontario Historical Society. The *CMAJ* apologizes for any inconvenience this error may have caused.

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1. Fletcher K. Sir Frederick Banting homestead sold to developer, family outraged. *CMAJ* 2007;176(12):1691-2.

DOI:10.1503/cmaj.070857