Line extension

Dr. Catherine Younger-Lewis ("Over the counter and into trouble," *Can Med Assoc J* 1997;156: 17) describes line extension as adding a number, a few letters or phrase to a recognized brand name and applying it to "an entirely different drug." This, in fact, is a rare type of line extension. Most involve products that retain their familiar active ingredient and indication, but add further ingredients or indications (e.g., Claritin Extra or Tylenol Cold Medication).

There are 2 audiences that manufacturers consider when developing line extensions. First are the consumers who will select and use the drug. The success of many of these products suggests that consumers appreciate the expanded range of choices. As Younger-Lewis points out, there is no evidence from consumer complaints, reports of adverse drug reactions or postmarketing research that line extensions have contributed to drug errors. However, the Nonprescription Drug Manufacturers Association of Canada (NDMAC) has joined Health Canada in an effort to examine this question through consumer research. The association is also working with the Canadian Public Health Association and other stakeholders on label comprehension and legibility.

Health care professionals are the other major audience for information on line extensions. Since professionals are often asked to recommend appropriate nonprescription therapies, they must have accurate and up-to-date information on these products. The NDMAC has worked with the Canadian Pharmaceutical Association to ensure that the *Compendium of Nonprescription Drugs* contains a comprehensive and accurate listing of our members' products and their active ingredients. Since this information is also vital to poison control centres, NDMAC members are required to forward information on new products (including line extensions) and product reformulations to the Canadian Paediatric Society, which maintains the database for Poisindex in Canada.

Recent Canadian research has shown that the nonprescription availability of nonsedating antihistamines has saved the health care system and consumers $16 million in treatment and absenteeism costs alone, with no negative effect on health outcomes.[1] As the importance of self-care and self-medication continues to grow, so do the roles of physician and pharmacist recommendations in this area. Cost-saving measures such as responsible self-medication merit a collaborative approach between the various sectors of the health care system. The NDMAC continues to seek opportunities for such collaboration.

Gerry Harrington
Director of Communications
Nonprescription Drug Manufacturers Association of Canada
Ottawa, Ont.

Reference

1. Anderson MJ, Morgan S. An economic analysis of self-medication in Canada [presentation]. 6th Canadian Conference on Health Economics, 1995, Waterloo (ON).

Dr. Younger-Lewis recommends taking a walk down a drug store aisle in a patient's shoes looking for examples of line extension. I took her advice and, being a pediatrician, chose the aisle for infant products. I recalled a Mead Johnson advertisement "introducing the NEW face of Enfalac's family of formulas: a face a mother could love."

The company's new labelling is indeed cleaner and more appealing but instead of the previous 2 types of Enfalac baby formula (plain or iron-fortified) there are now 4 more varieties. There are Enfalac Lactose Free and Enfalac Soy (a soy-protein-based formula with corn syrup solids instead of lactose). There are also 2 types of Enfalac with hybrid names: Enfalac Nutramigen (casein-hydrolysate-based formula) and Enfalac Next Step (skim-milk-protein-based formula for infants 6 months and older).

I am not aware of any harm resulting from this proliferation of Enfalac products, but I suspect that it causes confusion for some parents. I also suspect that parents assume that there are only minor variations between these formulations, since they share a common name. I have recently noted that several parents, whose infant's diet was temporarily switched to Enfalac Lactose Free because of an acute diarrheal illness, decided to continue feeding their baby this formula for an extended period, at a 45% increase in cost, according to my drug-store-aisle observation.

Allen R. Ciastko, MD
Kamloops, BC

Coincidence? I think not

The following letter is reprinted from The Actuary, *the newsletter of the Society of Actuaries, March 1997, with permission. — Ed.*

I read with some interest the press coverage of the article "Declining sex ratios in Canada" (*Can Med Assoc J* 1997;156:37-41), by Dr. Bruce B. Allan and associates.

I recently bought my teenage son a T-shirt at a souvenir shop. It read, "Hours in the day — 24; Beers in a case — 24: Coincidence?"

Many occurrences in our daily lives that at first appear to be coincidental turn out not to be. Let me add to the list.

Although you may not have noticed it, the ratio of male births to female births is dropping. Whereas the ratio used to be 105 boys to every 100 girls, there has been a measurable decline over the last 20 years (a loss of 2.2 male births for every 100 live births from 1970 to 1990). The experts are looking for an explanation for why this ratio, which used to be extremely stable, has changed. They cite older age of parents, environmental pollution, fertility drugs and so on. But maybe the explanation is more subtle and yet more profound.

We know that, in nature, the ecosystem maintains a remarkable stability. It is well documented that when certain species become overpopulated the size of their litters declines, and when their population is sparse, the size of their litters increases. This change can be quite remarkable, 2 to 3 times the number of live births in one cycle — whatever is needed to maintain the species.

For the human race, the ratio of 105 male births to every 100 female births was remarkable. Given the higher mortality rate among males, this ratio created almost equal numbers of males and females at the ages of reproduction.

However, things have changed. Survival in general has improved, especially at younger ages. The difference between the mortality rates among males and females, which until 1970 had always favoured females, has actually narrowed. Much of this can be explained by smoking habits. Deaths from accidental causes are down, especially, again, among young males.

Thus, were the natural world to continue to produce 105 boys for every 100 girls, we would have an oversupply of males in the reproductive ages, rather than an equilibrium. What was needed to compensate was a decrease in the ratio of male to female live births. And guess what? That is exactly what has happened!

Coincidence? I do not know. However, I do know that not everything in demography has an easy actuarial explanation, which is what makes the discipline so fascinating.

Robert L. Brown, FSA, FCIA, ACAS
Professor of Actuarial Science
University of Waterloo
Waterloo, Ont.
Received via e-mail

Touched and troubled by Amy

I was most impressed — and touched — by the article "Learning from Amy: a remarkable patient provokes anguished debate about rationality, autonomy and the right to die" (*Can Med Assoc J* 1997;156:229-31), by Dr. Stewart Cameron. Her experiences clearly show what occurs when autonomy is disregarded. These are exactly the kind of events that no one should have to put up with. Surely, in appropriate cases — competent adults with a terminal illness, for example — physicians should be allowed to provide assistance in dying to those who have repeatedly requested it as a means of sparing them the last few days or weeks of suffering. Such a physician-assisted death can well be the last act of love, mercy and compassion, not unlike the service veterinarians provide for suffering animals. Anything else would prolong dying, not living. Physicians should no longer look upon death as a failure or defeat, but as the relief it is in this kind of situation.

Rudolph W. Dunn, MD
South Surrey, BC

There are several troubling things about the decision to die recounted by Dr. Cameron. I especially agree with a statement in the article, "he also noted wryly that the current test of rationality was often concurrence with the opinion of one's physician."

I cannot help wondering whether the tone would be different if Amy was 27 or perhaps 17 rather than 77. I am concerned that this article was written by someone in family medicine, who had only a superficial knowledge of what was really happening with Amy, rather than by her psychiatrist, who had been able to spend some time with her. I cannot help wondering whether I am being sold the opinion of Cameron rather than the heart of Amy. What would this article have been like if someone had been able to get past her superficial defences to find out what was really in her heart?

This is the crux of the rush to grant people their "choice" to commit suicide: we are presented only with a very narrow, positive aspect of a person's decision to die. What about all of the other factors we do not hear about? What if a relative had been found? What if there was a concerned daughter, son or grandchildren who had lost track of Amy because of her delusional thinking? Why was she so isolated? Is that considered normal?

I wonder why Amy's first decision to "go swimming" was in a place where there were people in boats. Was there perhaps a deep longing to be rescued? And, somehow, the people in hospital who treated her sided with her "wish to die" rather than her deep longing to be rescued.

If any adult in our society really wishes to commit suicide, there is really nothing anyone can do to stop that person — we all have that choice. Patients who end up in the medical system are by that very fact requesting our assistance to help them out of a very difficult, painful and often poorly understood situation. It behooves us to ally ourselves with life, not with death.

William D. Gutowski, MD, BSc
Chilliwack, BC