This study compared the intake of appetite suppressants for more than 3 months in 4 countries in patients with PPH and in control subjects matched by age and sex. It found a 23-fold higher incidence of PPH in the patients who took the appetite suppressants than in the controls; this translates into 23 to 46 cases of PPH per 1 000 000 adults per year.[2]

However, the study did not control for body mass index. Although the actual weights of the subjects and controls were not reported, it was noted that the subjects were, on average, 1.6 times heavier than the controls.

Obese people have a high incidence of snoring and obstructive sleep apnea (due to adipose occlusions of the pharynx), inducing pulmonary vasoconstriction.[3,4] PPH is an accompaniment of the hypoxemia–hypercapnea of apnea.[5–8] Significantly obese patients are more likely than others to have taken a fenfluramine, particularly for a long period of time, because of the intransigence of their obesity; however, the population of significantly obese patients already has an increased incidence of PPH.

Thus, to confirm an increased incidence of PPH resulting from fenfluramine or dexfenfluramine, the control subjects would have to be matched obese people who had never received the drugs.

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**[The author responds:]**

Dr. Deitel is incorrect in asserting that Abenhaim and associates did not control for body mass in their study of appetite suppressant drugs and the risk of PPH. Unfamiliarity with logistic regression modelling may have led to this misunderstanding.

The authors clearly describe a logistic regression model that adjusts for weight-related confounding. Body mass index a (BMI) was dichotomized to a nominal independent variable representing BMI of less than 30 kg/m$^2$ and of 30 kg/m$^2$ or more. In their discussion, the authors did not consider whether the association between the use of appetite suppressants and PPH could be explained by the confounding effect of obesity. The possible interaction between BMI and appetite suppressants was tested and found not to be statistically significant; this led to the conclusion that "the effect of anorexic agents was the same whether patients had a high body mass index or not."

Before debating the risk of PPH with appetite suppressants, discussion should first focus on the health benefits of these drugs in reducing the long-term risks of obesity.

Dr. Gerald A. Faich, in his letter "Drug to treat obesity: editorial writer responds" (*Can Med Assoc J* 1997;156:978), finds himself and Dr. Manson misrepresented in their relationship with the manufacturers of fenfluramine and dexfenfluramine in the controversy surrounding the editorial they coauthored,[1] which accompanied the study by Abenhaim and associates. Faich states that he and Manson had served briefly as scientific consultants to Servier, but does not mention his association with Wyeth–Ayerst, the US distributor of dexfenfluramine. According to the editor of the *New England Journal of Medicine*: "We are aware that Dr. Manson's consultancy was not ongoing at the time the editorial was written, but Dr. Faich's consultancy with Wyeth–Ayerst was ongoing. He coauthored the editorial and his violation of our conflict-of-interest policy is unarguable."[2]

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## Alert over sound-alike drugs

The Motherisk Program in Toronto, a counselling service for pregnant women and their health care professionals on exposure to drugs and other substances or diseases in pregnancy, has become aware of 9 cases in which pinaverium (Dicetel) was dispensed by pharmacists instead of doxylamine–pyridoxine (Dicletin). The cases were in BC, Manitoba, Ontario, Nova Scotia and Newfoundland. The sole manufacturer of pinaverium (Solvay Kingswood, Scarborough, Ont.) is also aware of another unconfirmed report. Doxylamine–pyridoxine is a combination of an antihistamine with antiemetic properties and a vitamin $B_6$

supplement; it is available in Canada only by prescription. It has been shown to be safe during pregnancy, and Health Canada has labelled it for use in pregnancy, specifically to treat "morning sickness."[1] Pinaverium is a calcium antagonist specific to the gastrointestinal tract, which is used in the treatment of irritable bowel syndrome. There are no data on its safety during pregnancy.

In each case, it appears that the prescription was written correctly and was not the cause of the dispensing error. However, considering that there are many well-known examples of confusion among drugs with similar names,[2] the similarity between Dicetel and Dicletin may lead to more of these errors. To decrease the risk of prescribing or dispensing errors, physicians should consider writing the diagnosis and both the generic and trade name of the drug on each prescription when either doxylamine–pyridoxine or pinaverium is given to patients.[3]

If *CMAJ* readers are aware of any such errors, we would appreciate their informing us at the telephone number below.

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## When to scan, when to operate

In the article "Findings of negligence followed communication lapses in BC aneurysm case" (*Can Med Assoc J* 1997;156:49-51), by Karen Capen, the problem of resource allocation is a recurring theme. The comment by the Supreme Court judge that Jason Law's death was in part due to a reluctance to use computed tomography (CT) scanning "appropriately" could worsen the problem of inadequate resources for emergency surgery, which also appears to have contributed to Law's death.

The judge's emphasis on the family physician's reluctance to use CT scanning is unfortunate for medical reasons as well. Whereas a CT scan is difficult to obtain, a lumbar puncture can be performed safely if there is no clinical evidence of a mass lesion or localizing neurologic signs. The test is immediately available at almost any location and at a fraction of the cost of a CT scan. The presence of xanthochromia confirms the diagnosis. Used in conjunction with spectrophotometry, lumbar puncture is more sensitive than CT scanning in diagnosing a subarachnoid hemor-