assay conditions were modified, another cutoff point would have to be determined. A change in the specific activity of the labelled anti-human immunoglobulins, which can occur from one lot to another, would also lead to variation in the cutoff point, even if all other assay conditions remained constant.

On purely statistical grounds, it should be noted that the optimal cutoff points and the discriminative ability were determined from the same cohort of patients. Such a design tends to overestimate the performance of the marker. If the experiment were repeated in another cohort according to the predetermined cutoff points, a lower discriminative performance would be expected because the cutoff points would not be optimal for the new cohort. Furthermore, the 95% confidence intervals for sensitivity (not reported) were large (65% to 95% for IgA antigliadin antibody). Therefore, the results should be confirmed prospectively in another cohort (with the predetermined cutoff points) before antigliadin antibody testing is used to decide whether duodenal biopsy is appropriate for patients with suspected celiac disease. If the true sensitivity is only 70%, a large proportion of affected patients would be denied a diagnostic test and appropriate therapy.

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Received by email

[Two of the authors respond:]

We appreciate the opportunity to clarify a poorly worded sentence in our methods section. The optical density obtained with goat anti-human IgG or IgA antibodies without serum from a patient does in-
value of a screening test when a particular patient. In our study, the negative predictive value for IgA and IgG antigliadin antibodies was 98%. Nevertheless, duodenal biopsy should always be performed when there is a strong suspicion of celiac disease. No laboratory test is 100% accurate.

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BC’s physician–patient ratio

Lynda Buske’s article, “Physician supply: A change in direction?” (Can Med Assoc J 1997;157[3]:348), was interesting. However, because elderly patients make more visits to the doctor, it might be useful to rework the data to show the number of doctors relative to older patients — say those older than 60 years. In the case of British Columbia, we might find that there has not been an increase in the number of physicians relative to the number of elderly patients and that the province did not have more than its share of physicians.

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[The author responds:]

I calculated the proportion of the population over age 60 as of July 1, 1996.1 BC’s proportion stood at 16.8%, which is close to the national average of 16.4% and lower than the proportion in 4 other provinces. Interprovincial migration statistics2 (see Can Med Assoc J 1997;157[10]:1492) indicate that BC has traditionally recorded higher net gains of active physicians than other provinces. From 1990 to 1995, BC’s average annual gain was 118 active physicians who had moved from other provinces or territories, which represents a net gain of 707 physicians for the period.

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References