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[One of the authors responds:]

I thank Dr. Clark for reiterating the points I made in the editorial:

- certain high-risk subgroups of women are underscreened;
- special strategies are needed to engage these women in screening;
- primary care practitioners are important for the success of a screening program; and
- formal screening programs provide quality assurance and efficient systems for gathering and collating data not possible with ad hoc screening.

It was encouraging to read of the work of the CCPN and the special efforts that will be made to screen hard-to-reach groups of women.

The suggestion that my reference to the article by Hislop and associates[1] is misleading is itself misleading. The points still stand that rates of death from cervical cancer are higher among native women and that culturally sensitive initiatives are needed to engage these women in cervical cancer screening programs.

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A measuring stick for health care

The article "Inappropriate hospital use by patients receiving care for medical conditions: targeting utilization review" (*Can Med Assoc J* 1997;157[7]:889-96), by Carolyn DeCoster and colleagues, and the accompanying editorial, "Measuring the appropriateness of hospital use" (*Can Med Assoc J* 1997;157[7]:901-2), by Dr. Duncan J.W. Hunter, confirm many of the trends and practice patterns we have uncovered at our acute care facility.

Concurrent review of every patient admitted to hospital can be resource intensive when using previously described tools such as the appropriateness evaluation protocol[1] or the ISD-A review system.[2] At our hospital, a multidisciplinary team developed objective, accurate, easy-to-use criteria that were based on intensity of service and that could be applied quickly by the bedside nurse. Our "ACTIV index" allows concurrent assessment of the need for days of care in the hospital and barriers to care or discharge.[3,4] The database that has evolved over the past 4 years represents patient-specific data focusing on the patients' condition, not their diagnosis, acknowledges nonphysician elements and identifies interruptions to care plans.

We suggest that patients who have been "inactive" for 2 hospital days should be targeted for attention. Over 2 years, our own 2-day non-ACTIV project has reduced the number of never-ACTIV hospital days from 17.2% to 5.3% of total hospital days, for a saving in resources of $2.43 million. We have linked our review data to records from the Canadian Institute for Health Information, which allows us to analyse the practice patterns of specific diagnostic groups as well as physician characteristics related to those groups. This information shows variations in care delivery and can be used for physician education.

We too experienced the unexpected phenomenon of reduced nonacute admissions on weekends and evenings. We feel that the emergency department screens these patients well and makes good use of our on-call home care.

The health care process *can* be measured and managed. Identifying inpatients who are receiving inappropriate levels of care has given us an opportunity to direct patient care processes in a manner that has improved quality and resource use. With the bedside nurse as the reviewer who identifies every patient, every day, many of the barriers to care are identified immediately and broken down almost as fast. We believe that our CONTINUUM project, which uses the "ACTIV index," is a simple, objective, reliable and inexpensive tool for utilization review and could be adapted to suit the needs of hospitals of any size.

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BSE, variant CJD and infectious proteins

The Nov. 15, 1997, issue of *CMAJ* featured 4 articles on Creutzfeldt-Jakob disease (CJD), but none of the articles mentioned related work on "protein-like previral infectious particles." I would like to take this opportunity to correct that omission.

In 1982, at the same time that Dr. Stanley Prusiner published his paper on prions,[1] a similar mechanism for replication of the infectious proteins of scrapie was proposed,[2] and the

term protovirins (protein-like previral infectious particles) was suggested for these unusual infectious agents.

Two recent reports in *Nature*[3,4] outlined conclusive evidence from research centres in the UK that the agent causing bovine spongiform encephalopathy (BSE) is also responsible for variant CJD (vCJD). In the same issue of *Nature*, Jeffrey Almond and John Pattison commented on the possibility that the proteinaceous infectious agent in BSE and vCJD might have a cofactor.[5] This cofactor may consist of a short chain of nucleotides attached to the infectious protein and may act as a signal primer for the agent on the host's DNA. I therefore suggest that "protovirin" would be a more appropriate name than "prion" for these unusual infectious agents, which cause transmissible spongiform encephalopathies.

Concern was voiced in Canada in 1990 about the strong possibility that BSE might spread to humans,[6] and Agriculture Canada was urged at that time to slaughter all cattle that had been imported from the UK.[7] To the credit of that ministry, the recommended action was taken in 1991, after an animal imported from the UK was found to have BSE. Since then, no further cases of BSE have been reported in Canada.

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Don't forget the male victims of abuse

The article "Responding to our abused patients" (*Can Med Assoc J* 1997;157[11]:1539-40), by Dr. Barbara Lent, was both thoughtful and thought provoking. In many articles and editorials concerning abuse, there is an implicit assumption that the victims are women and girls and that the perpetrators are men. However, boys are also victims of abuse, and they too carry their scars into adulthood.[1] In addition, women are also perpetrators of abuse.[2]

The concept of male victims and male survivors of abuse is difficult for many to grasp because the stereotype that categorizes men as strong and silent is alive and well. This myth only serves to perpetuate the difficulty men have in seeking the help they need.

Abuse is a very real issue, and there is little doubt that women carry the greatest burden. However, the ability to abuse and the chances of becoming a victim are not gender specific, and they cross all religious, social and economic boundaries. We have come a long way in recognizing female victims of abuse, but much remains to be done. For male victims of abuse, we are only beginning to recognize the problem.

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