travel as a risk factor, only a third had obtained pretravel medical advice and fewer than 10% had taken a full course of antimalarial medication. Insect repellant had been used by 16%, and 64% had stayed where there were screens on doors and windows.

While the number of Canadians travelling overseas continues to increase, the incidence of malaria and other imported infectious diseases can also be expected to rise. As dos Santos and colleagues point out, the need to examine and overcome the barriers to seeking and following appropriate pretravel advice is of critical importance.

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Rethinking the numbers on adverse drug reactions

Namrata Bains and Duncan Hunter calculate the possible number of deaths due to adverse drug reactions (ADRs) by looking at the number of hospital admissions in which an ADR was reported and in-hospital deaths due to ADRs. They arrive at a figure of about 1824 deaths annually in Canada attributable to ADRs.[1]

Another way to calculate this figure is to extrapolate from data in published Canadian studies on in-hospital ADRs. About 15% of patients admitted to hospital experience an ADR.[2] Judging from data from the Ontario Medical Association[3] and a 5-year study of clinicopathological examinations of surgical specimens,[4] around 1.5% of ADRs lead to death. According to Bains and Hunter, there are 1.3 million discharges from Ontario hospitals each year. Using the figures given above — that 15.0% of these patients will have an ADR and 1.5% of those will die — 2925 such deaths occur every year in Ontario alone.

This estimate is likely skewed to the high side, since most ADR studies have focused on patients on medical wards, who tend to be sicker than those in other areas of the hospital. At the same time, it is also substantially higher than the one proposed by Bains and Hunter. The difference is probably largely due to underreporting. Bains and Hunter acknowledge that ADRs are underreported but do not comment on the magnitude of the problem. One estimate comes from a study by Borda and colleagues.[5] Although they found 535 ADRs among 936 monitored patients during a 3-year period, only 350 ADRs were reported for the other 75 373 nonmonitored patients admitted to the rest of the hospital over the same time. Bains and Hunter call for further research into hospital deaths due to ADRs based on careful analyses of routinely collected hospital separation data, but as long as ADRs go both unrecognized and unreported, their approach will consistently underestimate the true extent of the problem.

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Competing interests: none declared.

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Jeu de maux

Please allow me to make a correction to your French translation of "The Left Atrium." The French for "left atrium" is *l'oreillette gauche* and not *l'oreille gauche*, which is "the left ear"!

Nevertheless, the column is interesting.

Laurent Gervais, MD
Montreal, Que.

Le Dr Gervais a parfaitement raison, *atrium*, en médecine, se traduit par «oreillette». Il serait d'ailleurs assez tragique que nous ne le sachions pas. Cependant, nous n'étions pas convaincus que la traduction plus littérale «De l'oreillette gauche» serait porteuse d'une quelconque signification pour le lecteur francophone — en tout cas pas de celle que le titre anglais cherchait à communiquer.

Vous le savez sans doute, le mot latin «atrium» désignait dans l'antiquité la cour intérieure des maisons romaines. Au sens figuré, l'atrium est donc un lieu de rencontre. Pour ce qui est de la gauche, on dit volontiers, en parlant du côté gauche du corps, que c'est le côté du cœur. Ainsi, le titre anglais cherchait à réunir les notions de cœur et de rencontre. (Je ne vous cache pas qu'il a fallu extraire *a posteriori* du rédacteur en chef cette interprétation!)

En français, on dit aussi de la main gauche qu'elle est la main du cœur. De

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même, par extension, on pourrait dire de l'oreille gauche qu'elle est celle du cœur, mieux disposée à l'écoute attentive et facilitant ainsi la rencontre. Ce qui a donné, pour le meilleur ou pour le pire, «De l'oreille gauche». Peut-être aurait-il mieux valu nous éloigner davantage du jeu de mot sur «oreillette» pour éviter la confusion, mais voilà hélas les vissicitudes de la vie des traducteurs qui prennent leur travail… à cœur.

Marie Saumure, trad. a. (ATIO)
Coordonnatrice du service de traduction
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Coming in from the cold

The article by Caralee E. Caplan on diseases exacerbated by exposure to cold[1] was interesting, but it could have mentioned the cold urticaria syndromes, which can include cold-induced anaphylaxis.

For a more detailed discussion on these cold-induced syndromes, I would suggest an article by Alan A. Wanderer published in the *Journal of Allergy and Clinical Immunology*.[2]

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Norwood reconstruction

We read with interest the comments by Robert J. Adderley concerning the Norwood reconstruction for infants born with hypoplastic left heart syndrome.[1] We completely agree that it is the preferred procedure and that, for most of these infants, transplantation is not an option.

The author neglects to say that, in addition to being available in Toronto, Edmonton, Vancouver and Montreal, for a number of years it has been performed in Halifax at the IWK Grace Health Centre. Although the risk remains high, all 3 patients who underwent the procedure at our centre in 1998 survived and are doing well. Our oldest survivor is now 7 years old.

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Heroes in anesthesia

Although I appreciated Venita Jay's "story of a medical lifetime, told in a stamp,"[1] I beg to correct the name of another Canadian hero in anesthesia mentioned in that article. Dr. Harold (not Howard) Griffith pioneered the use of curare muscle relaxant to help his resident, Dr. Enid Walker, control a patient's muscle spasm and breathing, thus enabling the surgeon to operate successfully on Jan. 23, 1942, at the (now) Queen Elizabeth Hospital, Montreal.

Elizabeth Oliver (Malone), MD
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Hitting a sour note

As a musician and coauthor of *The Athletic Musician: a Guide to Playing Without Pain*,[1] reading Dr. Christine Zaza's critique of our book reminded me of music reviews that leave performers wondering whether the critic actually attended the concert. I was baffled to read that we focus primarily on shoulder impingement syndrome (20 of 175 pages) and string players (our apologies to bassoonists, bagpipers and sitar players, who indeed were left out of this edition).

The Athletic Musician is not intended to be a "comprehensive literature review" of injury prevalence statistics. However, we do support our introductory statement that "statistics … vary widely, ranging from high to very high," and we provided 5 references to published studies involving more than 4000 musicians. The injury prevalence rates reported in these studies varied from 10% to 87%, and not, as Zaza states, 57% to 87%.

Because our book was written for musicians rather than scientists, references for the general concepts it teaches appear in the bibliography. Footnoting each statement would have left us with a book that looked like a Mahler score — lots of black ink, and none too easy to read.

Musicians, whose education typically does not include the study of anatomy, are easy prey for any book that offers help. What a disservice to physicians to steer them clear of one of the few books on this subject that they could safely recommend for their musician patients.

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[The author responds:]

I not only "attended the concert," I attended several performances, and I listened as an epidemiologist and as a musician. Each time, I found several inaccurate statements, generalizations, contradictions and many opinions stated as fact. I note that Ms. Harrison did not object to these more serious criticisms within my review, which form the basis for my overall rating of "poor."

The book's focus on shoulder impingement syndrome is evident not by the number of pages devoted to this condition but by the emphasis given it, compared with the brief mention or omission of several common playing-related musculoskeletal disorders. For example,