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
Association médicale canadienne

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]

S.J. Tkachyk, MD
Associate Clinical Professor
Department of Pediatrics
University of Alberta
Edmonton, Alta.

References
1. Caplan CE. The big chill: diseases exacerbated by exposure to cold. *CMAJ* 1999;160(1):88.
2. Wanderer AA. Cold urticaria syndromes: historial background, diagnostic classification, clinical and laboratory characteristics, pathogenesis, and management [review]. *J Allergy Clin Immunology* 1990;85(6):965-81.

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.

David B. Ross, MD
Cardiovascular Surgery
IWK Grace Health Centre
Halifax, NS

Reference
1. Adderley RJ. Norwood reconstruction [letter]. *CMAJ* 1999;160(3):313.

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
St. Catharines, Ont.

Reference
1. Jay V. The story of a medical lifetime, told in a stamp. *CMAJ* 1998;159(8):911.

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.

Christine Harrison
Violinist Consultant
Stouffville Musicians' Clinic
Stouffville, Ont.

Reference
1. Zaza C. The athletic musician: a guide to playing without pain [book review]. *CMAJ* 1998; 159(11):1405-6.

[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,

carpal tunnel syndrome is mentioned briefly, but it is not defined and its symptoms and treatments are not described.

The presentation of prevalence is indicative of the more pervasive problems with the authors' use of research throughout the book. It is unfortunate that they sensationalize prevalence rather than provide musicians with information based on a careful review of the research literature.

I would argue that a book intended for musicians rather than scientists should still provide references so that musicians do not remain "easy prey." What a disservice to musicians it is to expect them to follow health advice without question. The authors themselves advise the reader to "be an informed customer" and to "ask for outcome statistics"; this is all I am asking of them.

I would not recommend referencing every statement, but references should at least follow sentences beginning "Study after study shows … ." Admittedly, including references would not remedy the more serious problems that arise when the authors misinterpret or draw erroneous conclusions from the literature. Considering these concerns and the authors' emphasis on back-extension stretches — advice that is given without appropriate cautions — I am unable to recommend this book to physicians or musicians.

Christine Zaza, ARCT, BMus, MSc, PhD
National Cancer Institute of Canada
Postdoctoral Fellow
University of Western Ontario
London, Ont.
Director, Canadian Network for
Health in the Arts

Debating thrombolysis in stroke

The gist of the article by Corinne Hodgson and Kathleen Whelan[1] is that thrombolysis for stroke is a good thing, enthusiastically endorsed by university-based neurologists. The implication is that physicians who practise emergency medicine in the community are providing suboptimal treatment because of the exigencies of practice away from wonderful academic centres.

The research is not as conclusive as Hodgson and Whelan imply. I am aware of 5 trials of thrombolysis in stroke, only 1 of which showed even modest benefit,[2] and 4 of which showed harm.[3–6] Furthermore, neurologists and radiologists have demonstrated[7] that CT scans have only 80% sensitivity in detecting central nervous system bleeding, which is not good enough. Thrombolysis for stroke is a dangerous therapy. It may help a very few selected patients, but it by no means offers the same benefit for stroke as it does for acute myocardial infarction.

Howard L. Bright, MD
Chilliwack, BC

References

1. Hodgson C, Whelan K. Are physicians ready for thrombolysis for acute stroke? A qualitative study. *CMAJ* 1998;159(6 Suppl):19S.
2. National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. Tissue plasminogen activator for acute ischemic stroke. *N Engl J Med* 1995(24):1581-7.
3. Hacke W, Kaste M, Fieschl C, Toni D, Lesaffre E, von Kummer R, et al, for the European Cooperative Acute Stroke Study (ECASS) Group. Intravenous thrombolysis with recombinant tissue plasminogen activator for acute hemispheric stroke. *JAMA* 1995;274(13):1017-25.
4. Multicentre Acute Stroke Trial — Italy (MAST-1) Group. Randomised controlled trial of streptokinase, aspirin, and combination of both in treatment of acute ischaemic stroke. *Lancet* 1995;346:1509-14.
5. Multicenter Acute Stroke Trial — Europe Study Group. Thrombolytic therapy with streptokinase in acute ischemic stroke. *N Engl J Med* 1996;335(3):145-50.
6. Donnan GA, Davis SM, Chambers BR, Gates PC, Hankey GJ, McNeil JJ, et al, for the Australian Streptokinase (ASK) Trial Study Group. *JAMA* 1996;276(12):961-6.
7. Schriger DL, Kalafut M, Starkman S, Krueger M, Saver JL. Cranial computed tomography interpretation in acute stroke: physician accuracy in determining eligibility for thrombolytic therapy. *JAMA* 1998;279(16):1293.

[One of the authors responds:]

The question posed in this study was not "should thrombolysis be used?" (an issue best studied in quantitative, clinical research) but rather, "if thrombolysis were to be approved, would physicians in different settings be willing, or have the resources, to use it?" The relevance of this qualitative research is underscored by Health Canada's approval in February 1999 of the use of tissue plasminogen activator for ischemic stroke. Many of the themes explored in theoretical terms in this study (e.g., time to hospital presentation and access to CT scanning) are now real and pressing issues for community-based physicians who may want to take advantage of this new therapy.

As noted in the article, thrombolysis should be viewed as only a part (probably a relatively small part) of good stroke management.

Corinne Hodgson, MA, MSc
Corinne S. Hodgson & Associates Inc.
Pelham, NH

Correction

Part of a sentence was inadvertently dropped from a recent article.[1] The sentence should have read: "When Dr. Parsons tried giving the babies irradiated ergosterol instead of cod liver oil there was a dramatic improvement, and the ward sister met us at the door and said, 'You've got it.'" We apologize for this error.

Reference

1. Brooks J. Alberta physician made a career of roughing it in the bush. *CMAJ* 1999;160:701-2.

Submitting letters

Letters may be submitted by mail, courier, email or fax. They must be signed by all authors and limited to 300 words in length. Letters that refer to articles must be received within 2 months of the publication of the article. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

Note to email users

Email should be addressed to **pubs@cma.ca** and should indicate "Letter to the editor of *CMAJ*" in the subject line. A signed copy must be sent subsequently to *CMAJ* by fax or regular mail. Accepted letters sent by email appear in the Readers' Forum of *CMA Online* (**www.cma.ca**) promptly, as well as being published in a subsequent issue of the journal.