



tions,⁴ we would like to add our concern about the use of antimotility agents in children infected with *E. coli* O157:H7. Three North American studies⁵⁻⁷ have suggested that drugs that slow intestinal peristalsis are associated with an increased risk of hemolytic uremic syndrome, or of more severe complications, when given to children infected with this pathogen. We strongly discourage their use in acute childhood diarrhea.

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The language of suicide

I agree with Mrs. Sommer-Rotenberg¹ that all must be done to promote a more compassionate attitude toward those who are affected by suicide. Abolishing the phrase "commit suicide" from the English language would be a step in the right direction.

Two opposing forces invade us as soon as we learn of the death by suicide of a loved one. There is a feeling of love and one of despair. Love leads us to believe that the suicide was not willingly done, whereas our despair warns us that this thought may just be a buffer against guilt. Our religious beliefs make us associate guilt and shame with the

wilful realization of a suicide.

After Michel, our 27-year-old son, had taken his life, we sat around the living room table discussing the aspect of choice in his suicide. I argued that he had not really chosen his suicide, while his younger brother argued to the contrary. With time, I came to accept my younger son's view that the suicidal act is in fact a choice — but then, we have to define the quality of that choice.

In medieval times the inquisitors would torture a heretic and invariably would obtain a confession (false, of course). Under intense suffering the accused one "chose" the path that led him or her to be burned at the stake. To me, the decision of the suicidal person is comparable: his or her choice is made to escape intense suffering. We cannot describe this choice as "free."

I believe that understanding the fact that one does not freely choose to end one's life helps us to deal with suicide with a more open and humanitarian attitude. To better understand suicide we have to realize that the cause is unbearable suffering, possibly in the presence of a mental illness.

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Urology: An unfairly neglected discipline of medical training

I would like to draw attention to the differential emphasis and importance given to examination and management of male and female genitourinary problems in medical school curricula. I studied medicine at Queen's University, where medical students are required to do a 3-week rotation in gynecology. In contrast, urology is not a mandatory rotation. Is gynecology more important than urology? Approximately equal numbers of gynecologic and urologic patients visit outpatient clinics, and I imagine that most men would argue that medical conditions affecting their

intimate anatomy and its function are as important as those affecting women. I would suggest that the discrepancy reflects the historical perspective that construed many of women's medical conditions as resulting from their dysfunctional "hysterical" wombs. Thus acquisition of gynecological examination skills became fundamental. But times have changed and so should the gender differences that exist in the way we teach and learn medicine.

During medical school, I was one of 2 women in my class who chose urology as a component of the surgical specialty training requirement. I wanted to confront my discomfort and lack of experience with examination of the male genitalia, and, as a future psychiatrist, I thought the rotation would prepare me for discussions about sexual dysfunction with my future patients.

In an informal poll of a number of my female colleagues, my suspicion that we could leave medical school without ever examining male genitalia was confirmed. Some of my classmates had never inserted a Foley catheter in a man. As residents, we will be called upon to do so by nursing staff, should they have difficulty placing the catheter. How are we to diagnose epididymitis without experience in examining the normal epididymis? During my family medicine rotation, supervised by a male physician, I was always asked by the patient to leave the room when there was a concern necessitating an examination of the genitals. Although I recognize that it is every patient's right to refuse to allow a student to be involved, I suspect that it was my gender, and not my status as a student, that precipitated these requests.

Historically, women have had no choice but to consult a male specialist about their genitourinary conditions, whereas men have been referred to a specialist of their own gender. Why are so few women encouraged to pursue a career in urology and why are so few accepted into urology specialty training programs in Canada? It may be that the predominantly male urologists wish to protect men from the anxiety provoked by talking with a woman about their most intimate medical conditions. With



few exceptions, male urology patients are obviously anxious when I enter the room. Their response is tri-phasic: first, a look of terror; next, an embarrassed and intent gaze at the floor; and finally, the smirk of shame as his gaze returns to me and he begins to describe his urologic condition. Once this tri-phasic hurdle is crossed, the interview proceeds as almost any other medical encounter. I contend that male patients do not need to be spared the anxiety and discomfort that female patients have long dealt with out of necessity; in fact, they might benefit from the interaction. They learn that they will not be shamed when talking about their most intimate concerns (erectile dysfunction, for example) with a woman, and this realization may improve their ability to communicate with female partners.

I met my educational goals during this rotation, and I think I learned to address sensitively the concerns of the patients in whose care I was privileged to be involved. Unfortunately, many of my female colleagues have not had the opportunity to acquire the skills they are expected to have. One of the urologists I worked with commented, "Female physicians aren't very skilled at investigation of men's urologic conditions." Quelle surprise! If all medical schools make urology a mandatory rotation, not only would future physicians benefit, but the change would also confer an equal importance to medical conditions of the male and female genitourinary systems, and would be another step toward achieving equality of men and women in the teaching and practice of medicine.

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Meta-analysis and adverse drug reactions

Evelinde Trindade and colleagues raise a number of important issues regarding meta-analysis and the reporting of adverse drug reactions in their article on adverse effects associated with

selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants.¹

Although meta-analysis has become an accepted method for statistically pooling outcome measurements, the results of such analyses may not uniformly predict the clinical outcomes of randomized controlled trials² and must be interpreted with caution. Limitations depend upon the selection of articles combined, the outcome criteria chosen, the heterogeneity of the studies included, the statistical technique used to pool the data, duplicate publication and interpretation of results.^{3,4}

Furthermore, meta-analysis was developed primarily to examine treatment efficacy, not safety. Trindade and colleagues report crude occurrence rates of adverse events for 2 classes of antidepressant medications. They found that SSRIs cause significantly more serotonergic events and tricyclic antidepressants more anticholinergic events. Did this outcome warrant the use of meta-analysis? Although the presentation of overall event rates may be useful,⁵ meta-analysis comparing the adverse events of treatments with widely different side effect profiles is unnecessary, as there is no conflict to resolve.

In addition, meta-analysis results are restricted to published clinical trials which, although they are ideal for examining efficacy in controlled environments, are not appropriate for comprehensive investigations of adverse events. The clinical trials used in the analysis by Trindade and colleagues had small samples and thus had sufficient power only to detect common adverse events. Moreover, clinical trial designs examine the effect of treatments in "ideal" patients, typically men and women between the ages of 18 and 65 years, who are otherwise healthy and not taking other medications. The effects of the medication in different populations, such as elderly people, adolescents and people with comorbidity, are thus not evaluated. As a result, uncommon and potentially serious adverse events may go unnoticed. We published a large case-series analysis of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) associated with SSRI use.⁶ We identified 736

spontaneous reports of SIADH to adverse-event reporting agencies and pharmaceutical manufacturers, of which 30 were published. Most of the cases occurred in elderly people. Yet despite the large number of case reports, this adverse event remains relatively unknown and unrecognized. A recent review found 35 additional published case reports since our original publication (12 of these published during the period between manuscript submission and publication). Only 4 case reports referenced the comprehensive case-series analysis. Given the serious nature of the event, we are troubled by the failure to recognize epidemiological or post-marketing surveillance study designs as valid sources for adverse event information.

Investigators who, like Trindade and colleagues, use meta-analysis in isolation may miss important, serious adverse events. Approaches that incorporate both clinical trial information and epidemiological and post-marketing surveillance research, including case reports, case series, and cohort and case-control studies, are necessary and appropriate to evaluate a complete, clinically relevant safety profile of therapeutic interventions.

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