made as part of a general discussion about why reference-based pricing policies may not substantially slow the growth of pharmaceutical expenditures in the long term and did not refer to the BC program specifically.

Lutchmie Narine
Mahil Senathirajah
Tina Smith
Department of Health Administration
University of Toronto
Toronto, Ont.

Reference

1. Narine L, Senathirajah M, Smith T. Evaluating reference-based pricing: initial findings and prospects. *CMAJ* 1999;161(3):286-8.

Bob Nakagawa and Rick Hudson suggest that captopril was the ACE inhibitor of choice in hypertension at the time of our study and that patients in hospitals might have been preferentially prescribed captopril. Our data, however, show that among first-time users of ACE inhibitors, the use of captopril was considerably lower than that of the other 2 agents; this does not indicate preferential use of captopril initially. Moreover, our study included only prescriptions dispensed on an outpatient basis, and availability of the drug on the hospital formularies should not have direct relevance to our study. Thus, we disagree with the claim that we present "little evidence" of the presence of therapeutic differences among ACE inhibitors on that basis.

Maurice McGregor contends that our conclusions are premature. He refers to a study by Caro and colleagues[1] that showed very low rates of persistence with ACE inhibitors in a similar cohort. We agree entirely that one should take such changes in drug use into account when trying to infer causality between drug use and subsequent use of health services, which our study did not. Our intent-to-treat analysis was a first step in using population-level data to assess whether agents belonging to the same therapeutic class differ in respects other than simply their chemical structures, such as the way they are prescribed to different patients and their impact on health services utilization. Additional studies accounting for complex patterns of drug use would be welcome.

Reference-based pricing policies aim to ensure that the more cost-effective medication is used. Although we are advocates of this approach, we believe that such policies should be carefully evaluated, not only in terms of health-related spending but also in terms of population health. McGregor's statement that "this is a provocative study that merits clarification" is certainly true. Indeed, our study had several methodological limitations, as Paul Grootendorst and Anne Holbrook correctly pointed out in an accompanying editorial,[2] and there may be other plausible explanations for the observed differences. However, population-based studies are essential in evaluating whether policies aimed at reducing costs may not in fact increase long-term costs and, more important, negatively affect public health.

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Samy Suissa
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McGill University
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References

1. Caro J, Speckman JL, Salas M, Raggio G, Jackson JD. Effect of initial drug choice on persistence with antihypertensive therapy: the importance of actual practice data. *CMAJ* 1999; 160(1):41-6.
2. Grootendorst P, Holbrook A. Evaluating the impact of reference-based pricing [editorial]. *CMAJ* 1999;161(3):273-4.

Much ado about Furbies

The research letter by Kok-Swang Tan and Irwin Hinberg regarding the Furby toy[1] raises questions. Was more than 1 Furby tested? There may be variance among Furbies. How did they obtain the Furby? When I tried to get one at Christmas time in 1998, they were virtually impossible to obtain. Did they use expensive AAA batteries, or cheaper ones that might reduce the electric and magnetic fields generated by the Furby? Finally, they state that the electric and magnetic field strengths generated by the Furby were about "70 times weaker" than those from a digital telephone. One time weaker would obviously mean no electromagnetic waves whatsoever, but it is hard to picture something that is 70 times weaker. Does this mean 1/70th, or 70% less? Or do the Furbies actually absorb electromagnetic waves, being in a negative mode?

Walter Ewing
Medical consultant
Ontario Ministry of Health and Long-Term Care
Toronto, Ont.

Reference

1. Tan K-S, Hinberg I. Furby does not interfere with medical devices. *CMAJ* 1999;161(8):971.

[One of the authors responds:]

We tested 2 Furbies. Neither caused any effect on medical devices. We had no difficulties in obtaining the Furbies. We obtained one from the Canadian distributor in Montreal and the other from a friend. Many colleagues had offered to lend us their Furbies for testing. We used 4 Energizer alkaline batteries. The voltage of each battery was checked after each test to ensure that it had not fallen below 1.50 V DC (about 94% of the initial voltage). As we pointed out in our paper the electric and magnetic field strengths generated by the Furby were weak — not zero. The term "70 times weaker" means 1/70th the strength.

Kok-Swang Tan
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Health Canada
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Old ways of treating TB may hold new appeal

As a physician who was involved in treating tuberculosis before the introduction of chemotherapeutic drugs, I found the article by Earl Hershfield

on the treatment of tuberculosis most enlightening.[1] I left the tuberculosis field when it seemed as if these drugs were going to revolutionize therapy, as they have to a great extent.

However, it seems that now we are facing an onslaught by drug-resistant bacilli. It may well be time for phthisiologists to look at the older treatments, such as collapse therapy by artificial pneumothorax and pneumoperitoneum, thoracoplasty, phrenic nerve crush and the old standby, prolonged bed rest. Perhaps some of us older physicians may be called on to help, while we are still around and remember how these treatments were carried out.

Frank Jackson
Diagnostic radiologist
Edmonton, Alta.

Reference

1. Hershfield E. Tuberculosis: 9. Treatment. *CMAJ* 1999;161(4):405-11.

A false-positive tuberculin test result

The tuberculin test can be helpful in the diagnosis of *Mycobacterium tuberculosis* infection. A recent *CMAJ* article mentions that false-positive test results can occur in those who have received BCG (bacille Calmette-Guérin) vaccination in childhood[1] but that positive reactions usually wane over time. No mention is made of the effect on the tuberculin test of intravesicular BCG therapy.

Patients with a positive tuberculin test reaction are usually asked if they have a history of BCG vaccination; however, most physicians do not ask their elderly patients if they have a history of intravesicular BCG therapy, which is commonly used for bladder cancer.[2] The following case illustrates how careful review of a patient's history and medical records confirmed a false-positive reaction.

A 74-year-old man presented with a 9-kg weight loss. A chest x-ray film revealed fibrotic changes in the left lower lobe. A Mantoux test was strongly positive with induration of 18 mm at 48 hours. The patient denied constitutional symptoms of fever, chills or night sweats. He had a mild dry cough. He denied hemoptysis. He had been smoking for 60 years and had a history of emphysema and throat and bladder cancer. There was no history of exposure to tuberculosis, and he did not recall having a BCG vaccination in childhood. He had a negative tuberculin skin test in 1995. Chest CT showed old granulomatous changes and emphysema. The possibility of active tuberculosis was entertained. Findings on the chest x-ray film were unchanged from 1991. Urine and sputum cultures for acid-fast bacilli were negative. Isoniazid prophylaxis was considered in view of induration of 15 mm or greater and recent conversion.

The patient did not know what treatment he had received for bladder cancer other than that it was some form of "chemotherapy," but hospital records confirmed that he received intravesicular BCG immunotherapy in 1996. The recent tubercular conversion was concluded to be false positive and isoniazid prophylaxis was avoided.

Among patients given intravesicular BCG treatment for superficial bladder cancer, up to 65% may have a positive tuberculin skin test reaction.[2] For patients with a positive reaction who have a history of bladder cancer, physicians should investigate whether they have had intravesicular BCG therapy before they commit to isoniazid prophylaxis.

Malvinder S. Parmar
Nephrologist
Timmins, Ont.

References

1. Menzies D, Tannenbaum TN, FitzGerald JM. Tuberculosis: 10. Prevention. *CMAJ* 1999; 161(6):717-24.
2. Lamm DL. Bacillus Calmette-Guerin immunotherapy for bladder cancer. *J Urol* 1985; 134(1):40-7.

Corrections

A recent article by Charlotte Gray[1] attributed information on the shortage of anesthetists in Canada to the Canadian Institute of Health Information. The information was correct, but it should have been attributed to the Canadian Anesthesiologists' Society.

Reference

1. Gray C. How bad is the brain drain? *CMAJ* 1999;161(8):1028-9.

The author byline for the specialty spotlight on xenotransplantation in the Nov. 16 issue[1] should have read "Lindsay E. Nicolle, MD."

Reference

1. Nicolle LE. Xenotransplantation: An animal future? *CMAJ* 1999;161(10):1291.

A copyediting error was made in a recent article by Paula Rochon and colleagues.[1] The first sentence in the Interpretation section (page 1406) should have read: "We found that almost half of all patients in Ontario aged 66 or more who survived an MI did not receive β-blocker therapy despite its proven secondary prevention benefit."

Reference

1. Rochon PA, Anderson GM, Tu JV, Clark JP, Gurwitz JH, Szalai JP, Lau P. Use of β-blocker therapy in older patients after acute myocardial infarction in Ontario. *CMAJ* 1999;161(11):1403-8.

The number of articles retrieved in a MEDLINE search using the search terms peppermint oil and irritable bowel was reported incorrectly in recent letters to the editor.[1,2] MEDLINE lists 13 articles on peppermint oil and irritable bowel.

References

1. Lépine P. Reaching a consensus on irritable bowel syndrome. *CMAJ* 1999;161(10):1237.
2. Paterson WG, Thompson WG, Vanner SJ, Faloon TR, Rosser WW, Birtwhistle RW, et al. Reaching a consensus on irritable bowel syndrome [reply]. *CMAJ* 1999;161(10):1237.

The author of the final letter to the editor on the CMA Charter for Physicians in the Nov. 30 issue[1] is Derryck H. Smith of Vancouver, BC.

Reference

1. Smith DH. Cheers and jeers for the Charter for Physicians. *CMAJ* 1999;161(11):1396.