Letters

Correspondance

Mandatory testing: not just an academic discussion

For me, Robert Colistro's recent comments on the testing of medical students for hepatitis B[1] are not part of an academic discussion. As an anesthetist, I risk pricking myself with a dirty needle at least 10 to 20 times per day. In spite of good technique, I have had many accidents — this is an occupational hazard that I have had to accept. I know I am negative for HIV because I am tested regularly, so I am not concerned with being forced to be tested. However, I feel that it is only fair that if medical students and physicians are forced to be tested then all patients admitted to hospital must also be screened.

In the past, patients were screened for sexually transmitted diseases without question or consent. What makes hepatitis B and HIV different? If you wish to violate medical students' rights, why not do it to patients too?

The term universal precautions is just the politically correct way to avoid forcing patients to be tested. We should have the right to know and protect ourselves.

I know that ethics specialists will not agree with me, but then they probably don't have anyone's blood on them at the end of the day.

Linda Ann Robinson
Department of Anesthesia
Ottawa Hospital
Ottawa, Ont.

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1. Colistro R. Hepatitis B and medical students [letter]. *CMAJ* 2000;163(3):259-60.

Harm reduction or reducing harm?

I am concerned that readers of the June 13, 2000, special issue of *CMAJ* on substance abuse may think that harm reduction is the central tenet of Canadian drug policy. While aspects of harm reduction have merit under specific conditions, I am deeply concerned that some truths are missing from the articles in this issue.

Although *Canada's Drug Strategy*[1] does advocate reducing the "harm associated with alcohol and other drugs to individuals, families, and communities," its first sentence states that "Canada's drug strategy reflects a balance between reducing the supply of drugs and reducing the demand for drugs."[1] Neither of these 2 chief aims of Canada's drug strategy can be called harm reduction as defined in the *CMAJ* articles. Reducing harm should not be confused with harm reduction.

The articles also neglect to point out that demand reduction — preventing use in the first place and reducing the number of users — not only is central to the strategy but in fact constitutes the most cost-effective intervention.[1] Instead, the articles give the impression that harm reduction — reducing harms without focusing on consumption —should form the crux of drug policy. Adopting harm reduction as the flagship for drug policy is neither compassionate nor visionary. It is simply a classic case of cop-out realism.

The articles tend to downplay the seriousness of illicit drug use, citing low incidences and the relatively greater economic costs of tobacco and alcohol. Low incidence does not necessarily mean a lesser problem. Harm reduction, adopted as an umbrella strategy, would simply widen the envelope of what drug use is considered acceptable. The message this strategy would send future generations alone cancels any benefits that I could envision.

Small 'h' harm reduction, in the form of specific strategies to help specific groups avoid harm while working toward abstinence or nonproblematic use (if such exists), does need to be considered. However, we should continue to concentrate on preventing drug use, making treatment much more comprehensive and accessible and sticking with drug users over the long haul of rehabilitation.

Colin Mangham
Director
Prevention Source BC
Vancouver, BC

Reference

1. Interdepartmental Working Group on Substance Abuse. *Canada's drug strategy*. Ottawa: Public Works and Government Services Canada; 1998. Available: www.hc-sc.gc.ca/hppb/alcohol-otherdrugs/publications.htm (accessed 24 Nov 2000).

[The editor of the *CMAJ* special issue on substance abuse responds:]

Although *Canada's Drug Strategy* does indeed start as quoted by Colin Mangham, it explicitly states its long-term goal to be "to reduce the harm associated with alcohol and other drugs to individuals, families and communities."[1]

In the *CMAJ* special issue, Eric Single and colleagues' objective quantification of mortality and morbidity does place illicit drug use in third place after alcohol and tobacco, which are both legal psychoactive substances.[2] But their report of 805 deaths and 6940 hospitalizations in 1995 can hardly be said to "downplay the seriousness of illicit drug use." The role that injection drug use now plays in the transmission of HIV and hepatitis C virus in Canada is further cause for concern. Benedikt Fischer and colleagues and Catherine Hankins argue that our traditional approach to illicit substance use is in part responsible for this tragic metric.[3,4]

Mangham posits a narrow definition of harm reduction — essentially use-tolerant interventions — yet also raises some of the concerns addressed by Yuet Cheung, who notes that "during its evolution [harm reduction] has been … criticized for sending the wrong message to drug abusers and the public and disparaged as promoting a defeatist position."[5]

Eric Single has written about the

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definitional problems and has called for an empirical definition of harm reduction.[6] In this conceptualization one cannot determine a priori whether a policy or program is harm reducing until one examines the evidence of its impact. Any program, be it demand or supply reduction, use tolerance or abstinence, that measurably reduced harm would be deemed harm reduction.

With its present drug strategy Canada spends heavily on law enforcement (more than $400 million annually[7]); these monies comprise the bulk of dedicated resources, yet there has been virtually no research on its effectiveness in reducing drug use or drug-related harm. Accepting and operationalizing an empirical approach would have advantages. As a nation we could develop and invest in policies and programs that were effective in reducing the prevalence of substance use and misuse, that reduced harm resulting from substance use and misuse and that provided users with effective options for managing or quitting substance use.

Perry R.W. Kendall
Provincial Health Officer
Victoria, BC

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3. Fischer B, Rehm J, Blitz-Miller T. Injection drug use and preventive measures: a comparison of Canadian and Western European jurisdictions over time. *CMAJ* 2000;162(12):1709-13.
4. Hankins C. Substance use: time for drug law reform [commentary]. *CMAJ* 2000;162(12):1693-4.
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Management of patients with uninvestigated dyspepsia

A recently published randomized controlled trial of the eradication of *Helicobacter pylori* in patients without ulcers who presented with functional dyspepsia[1] was reviewed in a *CMAJ* Clinical Update.[2] We believe the Clinical Update oversimplifies the management of dyspepsia in that it incorrectly leads the reader to believe that these results are applicable to the management of primary care patients with uninvestigated dyspepsia, when in fact this is not the case.

It is essential to distinguish between uninvestigated and investigated dyspepsia. By definition, functional dyspepsia is a diagnosis of exclusion after investigation has ruled out organic disease such as peptic ulcer, gastroesophageal reflux and, less frequently, gastric cancer.[3] For this, upper gastrointestinal endoscopy is the investigation of choice. Over half of patients with dyspepsia will have a normal endoscopy and they are said to have nonulcer dyspepsia.

There is indeed a lot of controversy about whether eradication of *H. pylori* infection in patients with functional dyspepsia leads to sustained improvement in symptoms. Although the study reviewed in the Clinical Update suggests that there is no benefit from eradication of *H. pylori* in patients with functional dyspepsia, a recent meta-analysis of 12 randomized controlled trials shows a modest risk reduction in dyspeptic symptoms resulting from eradication of *H. pylori* (risk reduction 9%, 95% confidence interval 4%–14%).[4]

Perhaps the clinically more relevant question is what is the value of a noninvasive *H. pylori* test-and-treat strategy in patients with uninvestigated dyspepsia in the primary care setting. A recently completed randomized controlled trial of 294 patients showed that 50% of patients randomized to active treatment for eradication of *H. pylori* had improvement in symptoms at 12 months compared with 36% in the group of patients randomized to a placebo.[5] Patients in this study did not undergo endoscopy, so it is not known how much of the improvement is attributable to patients with an ulcer diathesis.

Infection with *H. pylori* is also a risk factor for the development of gastric cancer. We might reasonably expect that eradication of *H. pylori* may provide the additional benefit of preventing some cases of gastric cancer, although there are not yet any data from randomized controlled trials to support this view.

In summary, we believe there are data to support a noninvasive *H. pylori* test-and-treat strategy in patients with univestigated dyspepsia who are less than 50 years old, who do not have alarm symptoms, who are not taking nonsteroidal anti-inflammatory drugs and who do not have symptoms suggesting reflux disease. This was clearly outlined in our recently published *CMAJ* supplement.[6]

Sander Veldhuyzen van Zanten
Department of Medicine
Queen Elizabeth II Health Sciences Centre
Dalhousie University
Halifax, NS
Nigel Flook
Department of Family Medicine
University of Alberta
Edmonton, Alta.
Naoki Chiba
Division of Gastroenterology
McMaster University
Hamilton, Ont.
for the Canadian Dyspepsia Working Group

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