

## Correspondance

days, before the arterial dissection? How many other confounding variables did they control for? What if a patient had a chiropractic adjustment and later that day went to their dentist or had their hair washed at a beauty parlour and then 2 days later had a violent sneeze or cough followed by a stroke?

The authors state that if a patient has neck pain after a chiropractic manipulation it represents an arterial dissection. I would like to see some hard evidence to support this statement. Some patients have neck pain after chiropractic adjustment because their spines are badly misaligned with a concomitant inflammatory process and there sometimes is correctional stress after the adjustment, such as the stress an orthodontist would create when adjusting braces.

Finally, what is the mandate of the Canadian Stroke Consortium? Have the members of the consortium applied as much effort to the study of other causes of stroke, such as adverse reactions to drugs, as they have to their study of adverse events caused by chiropractic?

**Alan O'Connor**

Chiropractor  
Ayr, Ont.

### Reference

1. Norris JW, Beletsky V, Nadareishvili ZG, on behalf of the Canadian Stroke Consortium. *CMAJ* 2000;163(1):38-40.

### [One of the authors responds:]

**M**y coauthors and I regret that Brian Lecker and Tim Pethrick found our commentary<sup>1</sup> so disturbing. We are primarily interested in collecting cases of probable dissection of the cervical arteries following sudden neck movement. The incidence of stroke following cervical manipulation, estimated by Lecker and Pethrick to be 1 per 1-3 million manipulations, is surely conjectural and in any case is irrelevant. We need careful studies that include rigorous follow-up and investigation of all cases of stroke following therapeutic neck manipulations. Only then we will be able to estimate the true extent of this problem.

We agree that there are other risk factors for stroke and that strokes may occur, by coincidence, following any activity.

In our study, however, we are only interested in documenting cases of cervical artery dissection. We have found that there are about 50 cases per year of stroke associated with cervical artery dissection and that manipulation of the cervical spine is associated with 27% of these.

Risk factors for stroke must be distinguished from risk factors for cervical artery dissection. There is no evidence that migraine, diabetes or smoking are risk factors for dissection. Our most recent, as yet unpublished, analyses confirm these findings; the only certain risk factors are neck trauma and in some cases genetic abnormalities of the vessel wall. Neck pain is the hallmark of the arterial tear in most cases, both in our study and in all other published studies. It is sudden and severe, and easily distinguishable from the chronic pain seen in patients attending for neck manipulation.

It might be helpful to attempt a case-control study, as Lecker and Pethrick suggest. However, the research question is not whether neck manipulation can result in dissection of a cervical artery, for it surely can, but rather whether some types of manipulation have a lower risk of dissection than others. We also need careful research to document the efficacy of neck manipulation as a therapy. Only then will we be able to weigh its cost, in terms of risk of cervical artery dissection and stroke, against its benefits.

We agree with Robert Sydenham that absence of proof is not proof of absence. Members of the medical profession and those manipulating necks for whatever reason must try to find the reason for these occasional tragic accidents and not try to pretend they never happened.

Alan O'Connor raises some interesting points. First, we must reassure him that all data were collected prospectively, but, of course, after the injuries occurred. Patients were questioned in hospital regarding details of their clinical picture and laboratory tests were performed accordingly. As he questions,

what delay can one accept between neck movement and later stroke? There are several autopsy reports of causal dissection with thrombus months after neck injury. We believe that the answers to O'Connor's other questions may be found by studying the materials on our Web site ([www.strokeconsortium.ca/PG.08.spontads.html](http://www.strokeconsortium.ca/PG.08.spontads.html)). Many of our findings are posted as they emerge and we are striving to keep the site up to date.

We thank our colleagues at the Canadian Memorial Chiropractic College, with whom we have had numerous helpful discussions. We initially attempted to share all data with them but came across the barrier of patient confidentiality, which we have not yet managed to overcome.

**John W. Norris**

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Stroke Research Unit  
Sunnybrook & Women's College Health  
Sciences Centre  
Toronto, Ont.

### Reference

1. Norris JW, Beletsky V, Nadareishvili ZG, on behalf of the Canadian Stroke Consortium. Sudden neck movement and cervical artery dissection [commentary]. *CMAJ* 2000;163(1):38-40.

### Lost in translation

**Y**our translator has made a humorous but bad translation in giving to "The Left Atrium" a significance absolutely out of order with "l'oreille gauche." Hilarious but significant. Unacceptable. Every first-grade student will translate "oreille" as "ear," and "atrium," a medical word, as "oreillette" of the heart.

**Jacques Desrosiers**

Obstetrician-Gynecologist  
Contrecoeur, Que.

### [The deputy editor of *CMAJ* responds:]

**W**e confess that this is not the first time we have heard from readers who are dissatisfied with the French translation of "The Left Atrium."<sup>1,2</sup> The

choice of “l’oreille” over “l’oreillette,” proposed by our francophone translators, was a deliberate attempt to be playful with connotations. In English, “The Left Atrium” has resonances with anatomy (we examine the heart — the metaphorical one — and its place in medicine), politics (dare we be left of centre?) and architecture (we offer an open, welcoming space).<sup>3</sup> All of this, whatever it means, is difficult to convey at one fell swoop in translation, but we would love to receive suggestions for an interesting alternative.

**Anne Marie Todkill**

#### References

1. Gervais L. Jeu de maux [letter]. *CMAJ* 1999; 160(10):1432.
2. Saumure M. Jeu de maux [letter] *CMAJ* 1999; 160(10):1432-3.
3. Todkill AM, Hoey J. Entering “The Left Atrium.” *CMAJ* 1999;160(1):67-8.

### The Latimer case

Despite the publicity that the Latimer case has received it is still difficult to understand the medical circumstances that drove the father of this unfortunate child to mercy killing. Why could she not have had stronger analgesics? Why was she subjected to many surgical procedures that failed to give her relief and even might have made her suffering worse? I think it appropriate for the medical community to be frank about what we might have done wrong.

**Herman J. van Norden**

Physician (retired)  
Vancouver, BC

### The future of medicine

I was disappointed that the work done by the Ontario Medical Association's Committee on Medical Care and Practice in the late 1980s was not acknowledged in the recently published Cana-

dian Medical Association policy statement entitled “The future of medicine.”<sup>1</sup> During my time at the OMA, the association made significant contributions to building innovative foundations<sup>2</sup> from which the CMA could take flight, but these contributions were rarely recognized.

**John Krauser**

Mississauga, Ont.

#### References

1. Canadian Medical Association. The future of medical [policy statement]. *CMAJ* 2000;163(6): 757-8.
2. Krauser J. Health-care reform, the future of medicine, and the return of power to the community. *Hum Health Care Int* 1997;13(4):131-5.

### Holiday levity

What a joy to read the holiday issue of *CMAJ* (Dec. 12, 2000), from cover to cover, I might add. An edition such as this leavens the dull bread of everyday life.

**James Baker**

Surgeon (retired)  
Victoria, BC

### Corrections

A recent article from the Canadian Task Force on Preventive Health Care contained 2 errors.<sup>1</sup> In Table 2, the number of women in the control group of the NBSS-1 trial was 25 216, not 24 216. In Table 3, the compliance with the first exam in the NBSS-1 trial was 99% (86–90% was the compliance with the second round of screening).

#### Reference

1. Ringash J, with the Canadian Task Force on Preventive Health Care. Preventive health care, 2001 update: screening mammography among women aged 40–49 years at average risk of breast cancer. *CMAJ* 2001;164 (4):469-76.

The competing interests statement in a recent article by Joseph LaDou and colleagues was incomplete.<sup>1</sup> One of the authors, Vito Foa, has given advice to and legal testimony on behalf of an Italian railcar construction company from which people have sought compensation for alleged asbestos-related illnesses.

#### Reference

1. LaDou J, Landrigan P, Bailar JC III, Foa V, Frank A, on behalf of the Collegium Ramazzini. *CMAJ* 2001;164(4):489-90.

### Submitting letters

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