Having the will to implement change is a larger challenge.

Ivo A. Olivotto
Clinical Professor
Radiation Oncology
BC Cancer Agency — Vancouver Island Centre
Victoria, BC
Christina Bancej
Head
Breast Screening Unit
Screening and Early Detection Section
Cancer Division
Population and Public Health Branch
Health Canada
Ottawa, Ont.
Lisa Kan
Screening Program Evaluator
Population and Preventive Oncology
BC Cancer Agency
Vancouver, BC

References

1. Shapiro S, Coleman EA, Broeders M, Codd M, de Koning H, Fracheboud J, et al. Breast cancer screening programmes in 22 countries: current policies, administration and guidelines. International Breast Cancer Screening Network (IBSN) and the European Network of Pilot Projects for Breast Cancer Screening. *Int J Epidemiol* 1998; 27(5):735-42.
2. *Organizing assessment*. Sheffield (UK): National Health Service Breast Screening Programme Publications; 1989.
3. Olivotto IA, Bancej C, Goel V, Snider J, McAuley RG, Irvine B, et al. Waiting times from abnormal breast screen to diagnosis in 7 Canadian provinces. *CMAJ* 2001;165(3):277-83.
4. Olivotto IA, Kan L, King S. Waiting for a diagnosis after an abnormal screening mammogram. *Can J Public Health* 2000;91:113-7.
5. Olivotto IA, Borugian MJ, Kan L, Harris SR, Rousseau EJ, Thorne SJ, et al. Improving the time to diagnosis after an abnormal screening mammogram. *Can J Public Health* 2001;92:366-71.

Oral corticosteroids for poison ivy dermatitis

Michael McKee and colleagues have performed a valuable service by documenting the finding that osteonecrosis of the femoral head may result from a short course of a moderate dose of corticosteroids in relatively young men.[1] However, I question their inference in a subsequent letter to the editor that oral corticosteroids are not an appropriate treatment for poison ivy.[2]

Poison ivy dermatitis, although self-limiting, may persist for 2 months or more. Intensely pruritic blisters and dermatitis may cover more than 50% of the body surface and involve areas that cause particular discomfort or embarrassment such as the genitals, face, hands and feet. If untreated, poison ivy dermatitis can result in prolonged absence from work and many sleepless nights. Mild to moderate cases can be treated with local therapy, but the only effective treatment for severe cases is systemic corticosteroids. Use of a potentially toxic therapy such as oral corticosteroids may in fact be more appropriate for a self-limiting condition than for a chronic condition that may recur after the therapy is discontinued.

It would be helpful if the incidence of avascular necrosis resulting from corticosteroid therapy could be more precisely defined. Do the authors have any suggestions why avascular necrosis does not seem to develop in women or men outside of the 20–41-year age range following short-term corticosteroid therapy? Are a significant majority of the authors' patients men who are 20–41 years old? Does alcoholism increase the risk of osteonecrosis with short-term corticosteroid therapy? One of their 3 patients who had poison ivy dermatitis was also an alcoholic and did not develop pain from osteonecrosis until 23 months after his oral corticosteroid therapy.[1]

I continue to prescribe oral corticosteroids for patients with severe progressive poison ivy dermatitis. I continue to warn them of the potential side effects, including the risk of avascular necrosis. Any further information to precisely define the risk would be of great service to my patients.

John Goodall
Clinical Assistant Professor
Division of Dermatology
Faculty of Medicine
University of Ottawa
Ottawa, Ont.

References

1. McKee MD, Waddell JP, Kudo PA, Schemitsch EH, Richards RR. Osteonecrosis of the femoral head in men following short-course corticosteroid therapy: a report of 15 cases. *CMAJ* 2001;164(2):205-6.
2. McKee MD, Waddell JP, Kudo PA, Schemitsch EH, Richards RR. Corticosteroids and avascular necrosis of the femoral head [letter]. *CMAJ* 2001;165(4):397-9.

[The authors respond:]

As John Goodall has noted, dermatology is not our area of expertise. However, we would make the following points.

First, none of the patients in our series had severe poison ivy dermatitis; they had been prescribed the medication after only a few days or at most a week of symptoms. Second, it is our understanding that there are very few prospective or randomized trials that support the use of corticosteroid medication to treat poison ivy dermatitis. Third, none of our patients remembered being warned about the potential side effect of osteonecrosis with the use of corticosteroid medication. Fourth, our patients told us emphatically that, had they known of such a risk, they would not have taken the medication.

Unfortunately, because our study was essentially a case series,[1] there is no way of knowing the denominator (the size of the pool of patients from which our cases were drawn). In addition, it is our impression that a number of risk factors for osteonecrosis, such as alcoholism, steroid use and trauma, may be additive in terms of causation, but this is extremely difficult to prove statistically.

The preponderance of young people in our series is explained by the fact that our patients were drawn from a referral population of younger people sent specifically for femoral head salvage rather than total hip arthroplasty. However, anecdotally, we are aware of similar cases in older patients. The preponderance of male patients remains unexplained.

Unfortunately, we are unable to provide any specific risk factors for the development of this condition following corticosteroid administration. We agree with Goodall that corticosteroid therapy should be reserved for use in patients with the severe form of poison ivy dermatitis and that patients should be appropriately warned about potential side effects. We look forward to the