

Having the will to implement change is a larger challenge.

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## 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.<sup>1</sup> However, I question their inference in a subsequent letter to the editor that oral corticosteroids are not an appropriate treatment for poison ivy.<sup>2</sup>

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.<sup>1</sup>

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.

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#### 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,<sup>1</sup> 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

results of prospective trials regarding the use of corticosteroids to treat poison ivy dermatitis.

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**Reference**

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.

## Preconceptional sex selection

In their excellent article on assisted reproductive technologies,<sup>1</sup> one controversial area that Laura Shanner and Jeffrey Nisker did not discuss is the use of preimplantation genetic diagnosis or sperm sorting for preconceptional gender selection for family balancing.

Some people are worried that the use of these technologies for preconceptional gender selection may affect the sex ratio in countries like India where most families want to have boys. I feel that couples should be free to select the sex of their babies. We have been offering preimplantation genetic diagnosis for sex selection for family balancing in our clinic in India since April 1999 and have treated 28 patients.

Thirteen of these patients have conceived, and 8 have given birth so far. I believe that if we allow people to choose how many babies to have and when to have them and even to terminate pregnancies if they wish, then we should allow them to select the sex of their child if they wish.

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**Reference**

1. Shanner L, Nisker J. Bioethics for clinicians: 26. Assisted reproductive technologies. *CMAJ* 2001; 164(11):1589-94.

**[The authors respond:]**

Like most bioethicists, we reject sex selection except to prevent serious sex-linked medical disorders. Our primary ethical guide remains unchanged: assisted reproduction creates new relationships and must always be understood in that context.<sup>1</sup>

Choosing which child to have is very different from choosing whether to have children at all. The US President's Commission observed that sex selection "seems incompatible with the attitude of virtually unconditional acceptance that developmental psychologists have found to be essential to successful parenting."<sup>2</sup> All children deserve respect regardless of their sex. Children must never be treated as custom-ordered commodities to satisfy our personal or social preferences.

Effects on third parties matter enormously. How do existing children perceive their parents' desire for the "right" (opposite) sex of child? Sex ratio imbalances are already causing social disturbances in parts of India and China where young men cannot find partners. Because sex selection most often prevents the birth of female children, the practice devalues women as a group.

For a medical procedure to be considered as ethical, the benefits must outweigh the risks. Subjecting fertile women to in vitro fertilization with preimplantation genetic diagnosis to choose the baby's sex is bad medicine,

both clinically and ethically. In vitro fertilization carries potentially life-threatening risks of ovarian hyperstimulation syndrome, deep vein thrombophlebitis and surgical complications. There is no evidence that "balanced" families are better families, or that "family completion" requires children of the opposite sex. Using physicians for preferential sex selection — even by less invasive sperm sorting techniques — misdirects scarce medical resources and, in our view, demeans the medical profession.

Ethics is never one-sided; the interests of everyone affected must be considered. We hope that pending Canadian legislation will discourage the provision of medical procedures for selecting nondisease traits such as sex. The medical risks of in vitro fertilization with preimplantation genetic diagnosis, and especially the social risks of eroding respect for children and women, must not be underestimated.

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1. Shanner L, Nisker J. Bioethics for clinicians: 26. Assisted reproductive technologies. *CMAJ* 2001; 164(11):1589-94.
2. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Screening and counseling for genetic conditions*. Washington: US Government Printing Office; 1983. p. 57.

## Mandatory vaccination of health care workers

In a commentary on mandatory vaccination of health care workers, Elizabeth Rea and Ross Upshur state that the burden involved for health care workers to accept vaccination "can be eased by providing free vaccine, [and] compensation for vaccine-related adverse