

The good old hockey game

Your recent report on the cardiovascular effects of recreational hockey¹ touched a nerve. Three years ago, one of the guys in our league had a myocardial infarction while playing. It scared us all, and a few weeks later I went onto the ice — not one of us stopped playing — wearing a heart-rate monitor under my gear.

I was able to monitor my heart rate continuously, and what I found closely paralleled the findings in this paper. I was astounded to see that my heart rate, which is normally around 80 when resting, shot up to 188, which is well above my cardiovascular exercise range.

Did this stop me from playing, or cause me to modify my on-ice activities? I am Canadian, eh, so of course not. But what it *did* do was reinforce my commitment to off-ice conditioning. Press coverage of the *CMAJ* study failed to reinforce one of its key points: that we can continue playing recreational hockey but we should be in the proper physical shape to do it wisely and safely.

The message for me was that in our attempts to recapture the glory of our youth we may forget to apply to ourselves the wisdom and common sense that our profession expects us to use with our patients.

Mitchell Shulman

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Reference

1. Atwal S, Porter J, MacDonald P. Cardiovascular effects of strenuous exercise in adult recreational hockey: the Hockey Heart Study. *CMAJ* 2002; 166(3):303-7.

Atwal and coauthors are to be congratulated for their study of the cardiovascular effects of adult recreational hockey.¹ I could not help but notice, however, that the ubiquitous problem of ringers entered into their study.

For those who do not play adult

hockey, a ringer is an ineligible (usually by virtue of age) but generally very skilled player. Unlike Little League baseball, where players (or their parents) may understate their age, in adult hockey the problem tends to be the opposite.

I was therefore somewhat bemused to notice that although the authors listed age greater than 35 years as an inclusion criteria, at least 15 of 113 study subjects were between 24 and 35 years (see Fig. 1). After reading the paper, one realizes that part of the value of an underage ringer is his higher maximum heart rate. Nonetheless, it is ironic that it appears to be just as difficult to keep some under-age adults out of an age-restricted study as it is to keep them off an age-restricted team. I'm sure Atwal and colleagues would find a sympathetic ear among convenors of adult hockey across the country.

Eric Alan Cohen

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Reference

1. Atwal S, Porter J, MacDonald P. Cardiovascular effects of strenuous exercise in adult recreational hockey: the Hockey Heart Study. *CMAJ* 2002; 166(3):303-7.

[One of the authors responds:]

I agree entirely with the comments from Mitchell Shulman. Keep playing but play smart. Play safe. Keep in mind, however, that maximum target heart rate is 220 minus the player's age. If I am 44, my maximum target rate is 176, and at the peak exercise target rate of 85%–90%, it would be 150–158. See www.hockeyheart.com.

In the second letter, Eric Alan Cohen is correct in that we wanted to study men at risk for cardiac events (age > 35), but several younger players were anxious to participate and measure their heart rates. This raises the question of

volunteer bias. Did those participating do so expecting to do well or to do poorly?

Paul MacDonald

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Blood-alcohol levels: show me the evidence

Regarding the CMA's recent position on lowering the legal blood-alcohol level,¹ in my practice as a forensic pathologist I see numerous deaths in vehicle accidents in which alcohol is involved. Almost invariably, the offenders are men, and the blood-alcohol level is over 0.2%. The record is 0.36% — a man who died at the wheel in a very minor accident from acute alcohol poisoning. My impression is that these accidents involve a hard core of consistent heavy drinkers who are often recurrent offenders. I cannot remember a death in which the blood alcohol was less than 0.2%.

Although this is anecdotal evidence based on limited experience, I do not see drivers who cause non-fatal accidents and injuries at lower blood-alcohol levels. Setting a level lower than 0.08% might have the effect of criminalizing a segment of drivers who are unimportant in accident causation. Indeed, we already have a mandatory 24-hour licence suspension for any driver who blows between 0.04% and 0.08%. What change in accident rates would a change in the laws produce?

There are unpleasant analogies here with gun-control legislation, which may ultimately criminalize me and my hunting partners. In 50 years of forensic autopsies, I have seen many deaths from gunshots, not one of which would likely have been prevented by our current legislation. I fear the CMA's position may have the same effect from a "politi-

cal correctness” standpoint; opposition would take a lot of courage.

What is the scientific evidence on which the CMA recommendations are based? In countries with a 0.5% legal limit, are accident and death rates from vehicle accidents significantly lower than those caused by Canadian drivers with blood-alcohol levels between 0.5% and 0.8%? Have comparisons been adjusted for regional differences in Canada — for example, between northern and southern Canada? My memories of driving in Austria, Germany and France are considerably more scary than those in Canada — general driving behaviour and the absence of speed limits appeared to be significant factors.

If you can produce scientific evidence, I am prepared to change my mind, but baseless pontificating should not be the CMA image.

H.E. Emson
Physician
Saskatoon, Sask.

Reference

1. CMA demands lower legal blood-alcohol level. *CMAJ* 2002;166(1):79.

A news item in a recent issue of *CMAJ* reported that the CMA has demanded a reduction in the legal blood-alcohol level.¹ This will result in criminalizing the social consumption of alcohol. I am a member of the CMA and I did not receive a request for a mandate for universal or even majority support from the membership for such a stance.

Before the CMA made this announcement, did the organization study the effects on driving in people with a blood-alcohol content between 0.05% and 0.08%?

Colin Dyack
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Reference

1. CMA demands lower legal blood-alcohol level. *CMAJ* 2002;166(1):79.

[The President of CMA responds:]

I would like to respond to the concerns of some of our colleagues regarding the validity of the CMA position regarding the lowering of the legal blood-alcohol level content for drivers from 0.08% to 0.05%, as well as the process employed in the formulation of this policy.

On July 23, 1997, the CMA Board of Directors reaffirmed a 10-year-old resolution that supported lowering the legal blood-alcohol content (BAC) for drivers from 0.08% to 0.05%.

This decision was based on a substantial body of scientific evidence demonstrating that significant impairment of driving-related skills (such as vigilance, alertness, and response times) occur in the majority of people at blood-alcohol levels even lower than 0.05%.

MADD Canada (Mothers Against Drunk Driving) recently released a review of international literature on this

Pfizer

Accupril

1/2 page 4 clr.

Repeat of Mar. 19, 2002