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[One of the authors responds:]

Marcel Dvorak and Charles Fisher concurred that, in our update of the guideline on the management of chronic pain in patients with breast cancer, no mention was made of surgical stabilization techniques for the treatment of axial skeletal pain due to bone metastases. The guideline was intended to cover the spectrum of pain in women with breast cancer, particularly in common situations. We emphasized the importance of recognizing that pain exists and the appropriate use of pain medications. This latter point is important because of the chronic and frequent underuse of opiates and co-analgesics. We stated that neurosurgical interventions (and we would include spinal stabilization here) are rarely required. Careful identification of patients who potentially might benefit from surgery is important.

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Adolescent stimulant use

Christiane Poulin unfortunately presented confounded and quite misleading findings in her paper on medical and nonmedical stimulant use among adolescents.[1] The major confounder is the inclusion in the student survey questionnaire of diet pills along with other stimulants prescribed specifically for behavioural and emotional disorders.

By combining prescribed stimulant diet pills — which are rarely prescribed to minors — with other prescribed stimulants in an anonymous student survey of prescribed and nonprescribed stimulants, the author obtained findings that do not match available data-based and school nurse survey findings on the prevalence of stimulants prescribed for adolescents.[2,3] For example, Poulin's finding of a 3:2 male to female ratio of adolescents reporting prescribed stimulant treatment is inconsistent with the customary finding of a 4–5:1 male to female ratio. (The ratio might have been narrowed by female respondents reporting the use of diet pills.)

A more striking disparity is the nearly 50% increase in the prevalence of stimulant treatment from grade 7 (median age 13 years) to grade 10 (median age 16 years). This finding is totally at odds with all available data,[2,3] including that of Poulin and colleagues from a study using triplicate prescription data on controlled substances in the same locale (Nova Scotia) in 1998.[3] Indeed, that study showed that student reporting of medical stimulant use was inaccurate (and confounded). The authors reported a male-to-female ratio of more than 4:1 for methylphenidate and dextroamphetamine prescriptions for school-aged youths. Furthermore, they reported that among youths aged 5–19 years, the highest prevalence of stimulant treatment was in youths aged 10–14 years (the age range in which students in grade 7 would be found), indicating that the prevalence in the 15–19 year age group (the age range in which students in grade 10 would be found) was lower.

The present use of nonprescribed amphetamine drugs among adolescents is high (4%–5% of students in grade 12 in the US report monthly use of these compounds) and nonprescribed diet pills are used as much by secondary school students.[4] Clearly, misuse of stimulants by youths is a concern and anonymous student surveys are useful to ascertain the rate. However, such inquiries need to be very precisely defined.

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[The author responds:]

Danel Safer and Julie Magno Zito question the gender and age ratios observed in our study and attribute differences between our study on stimulants as a group of drugs and studies elsewhere on methylphenidate (in particular) to the inclusion of diet pills in our questionnaire. The inclusion of diet pills along with other prescribed stimulants was noted in our discussion section as a limitation of the present study. However, as Safer and Zito comment in their letter, if stimulant diet pills are rarely prescribed to minors, then one would not expect the inclusion of diet pills to greatly influence male–female ratios of prescribed stimulants. In contrast, nonprescription diet pills are preferentially used by females.[1] Johnston and colleagues examined nonprescribed diet pills and stay-awake pills (caffeine,