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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:]

Daniel 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,

ephedrine and/or phenylpropano-amine) among American adolescent students. They concluded there was little distortion in their estimates of stimulants due to the marked decline in the US of the annual prevalence of the use of diet pills (from 20% in 1982 to 9.6% in 1998), in the presence of an increasing trend in amphetamine use.¹ Also, regarding male–female methylphenidate ratios, the gap between males and females has been narrowing.² Safer and Krager showed a narrowing of the ratio from 1:12 in 1981 to 1:6 in 1993 in middle school.³ Robison and colleagues reported a narrowing of the male–female ratio for children aged 5 to 18 years, from 5.4:1 in 1990 to 3.1:1 in 1995.⁴

Safer and Zito state that the prevalence of stimulant treatment in our study was 50% higher in 10th grade than in 7th grade. The estimate of past-month medical stimulant use, which is more likely to be accurate, shows no significant difference in the prevalence of medical stimulant use in 7th compared with 10th grade ($p > .05$). Of note, Zito and colleagues found that the largest increase in methylphenidate utilization had occurred among high-school aged youth of 15 to 19 years.² Our item on past-year medical use was analyzed primarily to determine the relationship between medical and nonmedical stimulant use. The medical and non-medical drug use items, symmetrical by design, date back to 1991 in the Nova Scotia Student Drug Use Survey and earlier in the case of the Ontario Student Drug Use Survey. Due to the 12-month recall period and discontinued therapeutic regimens and trials of therapy, the past-year prevalence estimate can be expected to be less accurate than the past-month estimate. However, this should not invalidate the association between past-year medical and non-medical stimulant use. In effect, our study revealed a relationship between medical and non-medical stimulant use based on several indicators, including the past-year use items.

Finally, marked geographic variability has been observed in methylphenidate utilization.^{2,5,6} Whereas the Nova Scotia

Prescription Monitoring Program provides some insight into methylphenidate utilization in Nova Scotia, we do not have comparable information for the other 3 Atlantic provinces. We do know significant differences exist in prevalence of use of several substances among adolescent students in the 4 provinces.^{7,8} Clearly, many factors could have influenced the age and gender ratios observed in our study.

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Provincial drug benefit programs

I hope that Andreas Laupacis' essay on provincial drug benefit programs will start an overdue debate on the decision-making processes involved in these programs.¹ As a rheumatologist practising in Ontario, I have often been frustrated by the inadequacy of limited use criteria for drugs that I wish to prescribe, for

example, certain bisphosphonates. Even more frustrating is the slowness with which the program deals with new and important agents such as etanercept, for which, at the time of writing, special requests still have to be made under Section 8. For drugs in this category, physicians must submit a written request to the Drug Programs Branch of the Ministry of Health and Long-Term Care indicating the reason why the drug is required for a particular patient.

If the Therapeutics Committee of the Ministry of Health and Long-Term Care makes its decisions from a societal perspective, then it should welcome transparency and conduct open meetings. It must, at least, request the views of interested parties other than of just the pharmaceutical companies when considering submissions. We would all like to see better evidence that the committee usually makes reasonable decisions.

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Obstetrics in family medicine

I applaud Dr. Godwin and colleagues¹ for advancing our knowledge in this area of importance to the discipline of family medicine and to the provision of obstetrical services to our population. The findings of this study are congruent with what our group found several years earlier² and with results of the Janus Project³ of the National College of Family Practice of Canada.

I would like to highlight several aspects to this issue that are critical in moving forward. One is the gender difference found in all above studies, with a preponderance of female practitioners intending to practise obstetrics on