group has not experienced an increase in heart disease, blood clots, strokes or breast cancer. This would lead us to conclude that medroxyprogesterone is the culprit, not estrogen and not necessarily the other very different progestins.

We have known for years that estrogen improves cholesterol levels[2,3] and that medroxyprogesterone negates that benefit.[4] The WHI has simply confirmed the negative effects of this one hormone preparation, nothing else. Hence, we should not jump to conclusions and condemn all other hormone preparations.

The risks and benefits of the other preparations remain to be painstakingly researched. Our menopausal patients expect nothing less.

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1. Yusuf S, Anand S. Hormone replacement therapy: a time for pause. *CMAJ* 2002;167(4):357-9.
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Competing interests: Dr. Lacroix receives speaker fees from an annual public speech on menopause sponsored by a pharmaceutical company. In making these presentations, she sponsors no products and follows the guidelines of the Society of Obstetricians and Gynaecologists of Canada.

[The authors respond:]

Regarding our commentary,[1] Lianne Lacroix speculates that the ongoing arm of the Women's Health Initiative Trial evaluating estrogens alone versus placebo has not been stopped because the results may be beneficial. Such speculation is dangerous, as there are no data from any randomized controlled trials that estrogen alone improves clinical outcomes in patients who take this preparation routinely. Until the results of the estrogen component of the WHI are available, prudence would dictate caution. While we do not "condemn all other hormone preparations," absence of proof of harm should not be assumed to mean proof of absence of harm. Therefore, it would be premature to recommend the routine use of any hormone preparation for the prevention of major vascular events until we have clear evidence of benefit from well-designed trials.

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Physicians' prescribing information: not for sale

Something seems to be missing from the CMA policy statement concerning physician information[1] that was recently published in *CMAJ*.

Drug companies have been reported to be soliciting physician prescribing profiles from pharmacists as a means of targeting their products to particular markets. My understanding is that the CMA does not approve of pharmacies releasing such information to drug companies, but I see nothing about this issue in the policy statement. Am I missing something?

John Elliott
Physician
Calgary, Alta.

[The CMA Associate Secretary General responds:]

Your impressions are correct: the CMA remains very concerned about the sale of physician prescribing data. This issue is addressed in a separate policy statement on the sale and use of individual physicians' prescribing data,[1] which was approved by the CMA Board of Directors in February 1997. The CMA continues to explore a range of options for addressing the sale of physician-specific information without consent.

Claude A. Renaud
Associate Secretary General and
Chief Medical Officer
Canadian Medical Association
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Reference

1. Statement of principles: the sale and use of data on individual physicians' prescribing. Ottawa: Canadian Medical Association; 1997. *CMAJ* 1997;156(3):424A-D. Available: www.cma.ca/cma/common/displayPage.do?pageId=/staticContent/HTML/N0/l2/where_we_stand/1997/2-1.htm (accessed 2002 Oct 8).

Correction

The first name of Marian Faulds was misspelled in a recent death notice, which also failed to note that her husband, G. Emerson Faulds, had been on the active staff at the Victoria and St. Joseph's hospitals in London, Ontario.[1]

Reference

1. Deaths. *CMAJ* 2002;167(7):832.