

These issues identify 3 specific classes or categories of “actors” — care providers and institutions; research funding agencies; and care governance and funding bodies — that would be required to revise their current operations for a *CMAJ*-type editorial policy to make sense.

We recognize that we are offering these observations unencumbered by any evidence on institutions’ actual views on these matters. We need data from a survey of institutional and care-provider attitudes toward revealing their identities in the context of prospective research studies that address clinical or organizational management practices. To what extent would widespread implementation of the *CMAJ* editorial position simply choke off researchers’ access to the only settings in which publicly accountable performance measures can be validated and the data collected? Perhaps this is all a “storm in a teacup,” and most institutions and providers would already be comfortable participating even with the understanding that they would be identified. But we suspect not.

We offer these thoughts as part of the debate on the important issues that your commentary raises and in the hope that some of the practical issues will be addressed soon. In the interim, neither CHSRF nor CIHR is planning to introduce a new “non-anonymity” condition on funding, at least in situations where a major part of a research project is development and validation of new measures, or the application of existing instruments in new contexts or for new purposes.

Jonathan Lomas

Executive Director
Canadian Health Services Research
Foundation (CHSRF)
Ottawa, Ont.

Morris Barer

Scientific Director
Institute of Health Services and Policy
Research
Vancouver, BC

Reference

1. Hoey J, Todkill AM, Flegel K. What’s in a name? Reporting data from public institutions [editorial]. *CMAJ* 2002;166(2):193-4.

[The editors respond:]

We still don’t understand how public health care institutions can be “transparent and accountable” and at the same time anonymous. Our editorial view is that data on publicly funded health care institutions should be available not only to researchers and regulators, but also to the public. We see no inconsistency between our claims that the public may be interested to know the track records of specific institutions and is capable of interpreting such information in a reasonable way. Rarely is the public interest served by the suppression of information, although in our commentary we allow for exceptions to our policy on disclosure where “there is a clear and demonstrable potential for net harm.”

We agree with Shoo Lee and colleagues and with Jonathan Lomas and Morris Barer that studies of the validity of measures used to compare institutions need not reveal the names of the institutions (perhaps ever). The aim of such studies is the measuring stick, not the measured. Further, as Lomas and Barer rightly state, journals must respect existing agreements and “grandfather” such papers. (As we did.)

But what about the future? If anonymity of our public institutions derives from the patronizing attitudes of some of our health care facilities and professionals, then those attitudes need to change. Lomas and Barer are right that we need some data. But we need this data not just on provider and institutional attitudes, but also on what the public wants.

Lastly, we understand the reluctance of the directors of 2 key institutions “to introduce a new ‘non-anonymity’ condition on funding”: They are near the front lines and want to encourage, not discourage research. But they should also take the lead and publicly promote more public disclosure among our institutions and funding agencies so that non-anonymity becomes the rule rather than the exception. Perhaps their letter is a start.

John Hoey

Anne Marie Todkill

Ken Flegel
CMAJ

Mercury in seafood

I am writing to alert physicians to a common but infrequently considered source of mercury.

I recently saw a young woman who was referred to me because of high levels of blood mercury. The patient, who was 26 years old, had been diagnosed with multiple sclerosis (by MRI) following a bout of optic neuritis and peripheral neuropathy, both of which resolved spontaneously. Yet because of her interest in a possible correlation between mercury levels and dental fillings, she had asked her family physician to measure her blood mercury level. The result, 63 nmol/L, was markedly elevated (normal 0 to 49 nmol/L). However, several case-control studies have failed to find a relationship between dental amalgams and development of multiple sclerosis.¹⁻³

On examination she appeared well and physical examination was entirely within normal limits.

Past medical history revealed a childhood exposure to mercury brought home by her father, who was a dentist, and more recently to a broken mercury-containing thermostat in her apartment. (Mercury poisoning has resulted from exposure to devices that contain mercury such as sphygmomanometers.⁴)

The patient lived with her mother and both women worked at a local hotel. There had been recent renovations to interior of their apartment including replacement of drywall. The building was 35 years old. She had no unusual hobbies that might have exposed her to mercury. Both she and her mother consumed health food supplements. Her mother’s levels of blood mercury were normal.

Further questioning revealed that both the patient and her boyfriend enjoyed sushi and other seafood, eating out at restaurants 4 to 5 times a week. Her boyfriend, aged 22, had a blood mercury level that was elevated (59 nmol/L).

It has been widely publicized that larger fish such as shark, swordfish and fresh or frozen tuna contain high levels of mercury. A recent report revealed that in 10 of 11 patients referred to an occupational health referral clinic in the US

because of elevated mercury levels thought to be due to environmental or workplace exposure, those levels were instead due to dietary intake.⁵ Health Canada, in May 2001, recommended that such fish be consumed not more than once per week.⁶

Environmentally acceptable levels of mercury are based on what would be unlikely to cause health effects even in high-risk situations such as pregnancy. Nonetheless, in this era of cholesterol anxiety, many health professionals encourage seafood consumption. Physicians need be aware that toxic mercury levels can result when exposure occurs at higher than recommended levels.

John Sehmer

General Practice – Industrial Medicine
Vancouver, BC

References

1. Casetta I, Invernizzi M, Granieri E. Multiple sclerosis and dental amalgams: case-control study in Ferrara, Italy. *Neuroepidemiology* 2001;20(2):134-7.
2. McGrother CW, Dugmore C, Phillips MJ, Rayond NT, Garrick P, Baird WO. Multiple sclerosis, dental caries and fillings: a case-control study. *Br Dent J* 1999;187(25):261-4.
3. Bangsi D, Ghadirian P, Ducic S, Morisset R, Ciccioppo S, McMullen E, et al. Dental amalgam and multiple sclerosis: a case-control study in Montreal, Canada. *Int J Epidemiol* 1998;27(4):667-71.
4. Rennie AC, McGregor-Schuerman M, Dale IM, Robinson C, McWilliam R. Mercury poisoning after spillage at home from a sphygmomanometer on loan from hospital. *BMJ* 1999;319:366-7.
5. Kales SN, Goldman RH. Mercury exposure: current concepts, controversies, and a clinic's experience. *J Occup Environ Med* 2002;44(2):143-54.
6. Health Canada. *Advisory: Information on Mercury Levels in Fish*. 2001 May 29. Available: www.hc-sc.gc.ca/english/protection/warnings/2001/2001_60e.htm

Cesarean trends

In commenting on the study by Eason and colleagues¹ Scott Farrell appears to have inferred from their findings that there is support for elective cesarean birth as a way of reducing the risk of anal incontinence after vaginal delivery.² We disagree with his interpretation. Furthermore, from a public-health perspective this line of argument is alarming.

Eason and coworkers showed a cumulative incidence of fecal (3.1%) and flatal (25.5%) incontinence. However, these figures include the category "less than once weekly" — a category of du-

bious clinical significance and, likely, one associated with little disruption to quality of life.

Nonetheless, we agree with Farrell that obstetricians and mothers should take an explicit risk-benefit approach when discussing the option of cesarean delivery. We recently studied 8327 consecutive births by women resident in Hong Kong. We found that cesarean section compared to normal vaginal delivery was a risk factor for not initiating breast-feeding (adjusted odds ratio [OR] 1.52, 95% confidence interval [CI] 1.34–1.73) and for breast-feeding less than 1 month (OR 1.25, 95% CI 1.00–1.56), and remained a significant hazard against total breast-feeding duration (hazards ratio [HR] 1.16, 95% CI 1.04–1.30).³ Although it is generally recognized that most mothers recover from birth-related pelvic injury within months of giving birth, the adverse health and developmental effects for infants due to low breast-feeding rates persist well into childhood and adolescence.⁴

The global epidemic of cesarean section is a matter deserving international attention. For instance, Hong Kong's caesarean section rate rose rapidly from 22% in 1993 to 27.4% in 1999, benchmarked against the WHO's recommended upper limit of 15%.⁵ We must not allow the upward trend to continue, certainly not based on inappropriate extrapolation and interpretation of data collected for another purpose.

Gabriel M. Leung

Clinical Assistant Professor

Tai-Hing Lam

Chair Professor and Head

Lai-Ming Ho

Computer Officer

Thuan Q. Thach

Statistician

University of Hong Kong Medical

Centre

Hong Kong

References

1. Farrell SA. Cesarean section versus forceps-assisted vaginal birth: It's time to include pelvic injury in the risk-benefit equation. *CMAJ* 2002; 166(3):337-8.
2. Eason E, Labrecque M, Marcoux, Mondor M. Anal incontinence after childbirth. *CMAJ* 2002; 166(3):326-30.
3. Leung GM, Lam TH, Ho LM. Breast-feeding

and its relation to smoking and mode of delivery. *Obstet Gynecol* 2002;99:785-94.

4. Cunningham AS, Jelliffe DB, Jelliffe EF. Breast-feeding and health in the 1980s: a global epidemiologic review. *J Pediatr* 1991;118:659-66.
5. Leung GM, Lam TH, Thach TQ, Wan S, Ho LM. Rates of cesarean births in Hong Kong: 1987-1999. *Birth* 2001;28:166-72.

[The author responds:]

Leung and colleagues raise 3 issues: 1) that my conclusions concerning the protective effect of cesarean section for anal incontinence were based upon the article by Eason and colleagues,¹ 2) that concerns about the detrimental effect of cesarean birth on breast-feeding rates should carry greater weight with women than concerns about pelvic floor injury associated with vaginal birth, particularly assisted vaginal birth, and 3) a global epidemic of cesarean delivery currently exists and must be curbed.

In fact, Eason and colleagues' study did *not* find that cesarean section afforded any protective effect from anal incontinence. I took issue with this conclusion based on evidence from our own prospective study as well as from the work of other authors.² In a study involving 690 women, we found that forceps delivery was associated with a higher incidence of both flatal (RR 2.6) and fecal (RR 3.6) incontinence when compared to cesarean delivery. On the other hand, elective cesarean delivery appears to protect the anal continence mechanism by preserving muscle strength as well as anal sphincter size.³ Although occasional flatal incontinence is unlikely to have a significant impact on quality of life, fecal incontinence has serious sequella.⁴

Faced with a choice between a trial of forceps and cesarean delivery, women must weigh the risks and benefits of these alternatives. Modern cesarean delivery in controlled circumstances is a very safe procedure for both the mother and the fetus. Forceps delivery, on the other hand, while associated with a low risk of fetal trauma, has a significant maternal risk of both short- and long-term sequelae from pelvic trauma. Faced with the choice between cesarean and forceps delivery, would a woman consider a 16% in-