

cause of the timing of the screen and may require treatment in any case. Those with GBS infection in a previous pregnancy should be treated in any case. Maternal fever in labour would be treated in the interests of both mother and baby. Therefore, strategies A and B would result in all pregnant women being screened at significant cost.

On the basis of the information presented by the task force, strategy C appears to be the most clinically efficient and cost-effective way of preventing GBS infection in neonates.

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References

1. Prevention of group B streptococcal infection in newborns. Recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2002;166(7):928-30.
2. Society of Obstetricians and Gynaecologists. Statement on the prevention of early-onset group B streptococcal infection in the newborn. *J Soc Obstet Gynaecol* 1997;19:751-8.

[The Canadian Task Force on Preventive Health Care responds:]

R.J. Morrow does not specify the way in which there is an apparent mismatch between our recommendations and the information we presented in our report on preventing group B streptococcal (GBS) infection in newborns,¹ but in the interests of complete clarity we would like to direct readers to the full technical document, which is available at www.ctfphc.org/Full_Text/CTF_GBS_TR_final.pdf.

In reply to Morrow's comment regarding inconsistency among national guidelines, we can only reply that we followed an evidence-based process to determine the effectiveness of the 3 strategies and found insufficient evidence to recommend for or against strategy C. Other factors that might be used in decision-making include cost, feasibility and patient preferences, and do not factor directly into our recommendations, although we attempt to address them in other parts of our article.

We disagree with Morrow's statement that strategies A and C could be

used to treat the same group of women. If strategy C were adopted, all women with at least one risk factor would receive intrapartum prophylaxis. Many of these women would be negative for group B streptococcus and therefore a larger number of women would be exposed to antibiotics than in strategy A. Finally, our recommendation statement only addresses women at or close to term gestation.

Many organisms other than group B streptococcus cause early-onset sepsis. Chorioamnionitis carries a high risk for neonatal infection, and women with this condition should receive appropriate intrapartum treatment regardless of their GBS colonization status.

Finally, it should be made clear to health care providers and parents that none of these strategies can prevent all cases of early-onset GBS infection.

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Telehealth: Is it safe?

We thank Patrick Potter for taking the time to comment on telehealth in his recent letter.¹ He may not realize that the goal of triage is not to make a diagnosis. As his anecdote illustrates, it is foolhardy to attempt to "make the diagnosis over the phone." Rather, the goal of telephone nursing assessment is symptom triage. Clearly, it is not diagnostic certainty that allows for sorting to be accomplished, and this cannot be done by rote or scripted automations. Trained and experienced nurses, who listen reflectively, aided by tools that prevent gaps in information gathering and documentation, have been providing this function for at least 15 years.² No suit against a triage provider has successfully shown an inability to sort out

the emergently ill. This safety record stands in the highly litigious atmosphere of our US neighbours, where millions of triage calls are conducted annually (Raul Seballos, Cleveland Clinic, Cleveland: personal communication, 2002). The originators of this type of triage were pediatricians, seeking relief from the onerous after-hours phone calls that plague most acute care physicians.

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References

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2. Poole SR, Schmitt BD, Carruth T, Peterson-Smith A, Slusarski M. After-hours telephone coverage: the application of an area-wide telephone triage and advice system for pediatric practices. *Pediatrics* 1993;92(5):670-9.

Hyponatremia and SIADH

In their article on hyponatremia,¹ Haralampos Milionis and colleagues do not mention an interesting diagnostic tool: the detection of high-molecular-weight forms of vasopressin. The presence of this in plasma, sometimes in large amounts, is highly suggestive of the syndrome of inappropriate secretion of antidiuretic hormone (SIADH) associated with a carcinoma of the lung.²⁻⁴

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2. Yamaji T, Ishibashi M, Hori T. Proreninogen in human blood: a possible marker of ectopic vasopressin production. *J Clin Endocrinol Metab*