I am not at all surprised that they found a lack of enthusiasm among surgeons.

Lorne Bellan
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References

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2. Steinberg EP, Tielsch JM, Schein OD, Javitt JC, Sharkey P, Cassard SD, et al. The VF-14. An index of functional impairment in patients with cataract. *Arch Ophthalmol* 1994;112:630-8.
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4. Picard A. Do your homework, study urges doctors. *Globe and Mail* [Toronto] 2001 May 29;Sect A:1-6.
5. Wright CJ, Robens-Paradise Y. *Evaluation of indications and outcomes in elective surgery: a feasibility study in the acute care hospitals of the Vancouver/Richmond Health Region*. Vancouver: RESIO; 2001 May. Available: www.resio.org/FINAL_RESIO_Report.pdf (accessed 2002 Dec 16).
6. Javitt JC, Steinberg EP, Sharkey P, Schein OD, Tielsch JM, Diener M, et al. Cataract surgery in one eye or both. A billion dollar per year issue. *Ophthalmology* 1995;10:1583-92.

Charles Wright and colleagues[1] reported highlights of the RESIO study, including information about patients undergoing cataract surgery. The comprehensive report of that study[2] states that 10% of the patients had preoperative vision better than 20/50 and therefore might not have met the cataract surgical guidelines. Wright and colleagues have suggested that these patients might have undergone unnecessary surgery.[1] In fact, the policy manual of the College of Physicians and Surgeons of British Columbia states that patients with vision better than 20/50 but significant functional visual impairment are suitable candidates for cataract surgery.[3] For example, bus drivers, police officers and airline pilots need vision that is considerably better than the 20/50 level to function in their jobs.

Wright and colleagues claimed that the outcome of cataract surgery was poor.[1] In the RESIO study, the average visual function score before cataract surgery was 79 out of 100, and this score rose to 88 after the surgery.[2] I suspect that the 9-point improvement in patient-reported visual function was interpreted as a very small improvement and therefore a poor outcome. However, given that 100 represents absolutely no visual disability, a score of 88 is in fact an excellent outcome, and this score was higher than the postoperative scores for any of the other surgical procedures in the study.

In the routine cataract assessment program at the University of British Columbia, 94% of the patients have better visual acuity, 3% have the same visual acuity, and 3% have worse visual acuity after cataract surgery.[4] The RESIO study measured objective visual acuity before but not after surgery. It would have been helpful to have objective postoperative data to determine why, if only 3% had worse vision, 26% scored worse on their visual function form. We are currently re-examining the RESIO data to try to answer some of these questions.

Duncan P. Anderson
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1. Wright CJ, Chambers GK, Robens-Paradis Y. Evaluation of indications for and outcomes of elective surgery. *CMAJ* 2002;167(5):461-6.
2. Wright CJ, Robens-Paradise Y. *Evaluation of indications and outcomes in elective surgery: a feasibility study in the acute care hospitals of the Vancouver/Richmond Health Region*. Vancouver: RESIO; 2001 May. Available: www.resio.org/FINAL_RESIO_Report.pdf (accessed 2002 Dec 16).
3. Guidelines for the management of cataract in adults. In: *Policy manual College of Physicians and Surgeons of British Columbia*. Vancouver: The College; 1996 Mar. Available: www.cpsbc.ca/policymanual/guidelines/cataracts.htm (accessed 2002 Dec 16).
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[One of the authors responds:]

LeBlanc and Bellan both take issue with our conclusion,[1] based on VF-14 questionnaire results, that cataract surgery is currently being performed for doubtful indications in a substantial proportion of patients. There is no perfect instrument to measure visual function, but the VF-14 was developed by ophthalmologists for their use in assessing cataract patients and is apparently acknowledged as the best tool there is. Anderson also acknowledges that on the VF-14 "a score of 88 is in fact an excellent outcome" and that "100 represents absolutely no visual disability." It is therefore difficult to understand the decision to operate in the 15% of patients who scored above 95, and especially in the 4% of patients with the astonishing score of 100, at the time of preoperative assessment in our study. In choosing the VF-14 for our study we relied on the ophthalmology literature, the epidemiologists working in the University of British Columbia Department of Ophthalmology and the advice of the ophthalmologists associated with the project. The consensus remains (as quoted by Bellan himself) that the subjective VF-14 score correlates more strongly with visual function than any objective measurement of visual acuity made by the surgeon. Anderson's last paragraph seems to deny this accepted conclusion from cataract outcomes research, and he returns to suggesting that measured visual acuity, rather than the VF-14, is the most appropriate measure of outcome.

In claiming that the ophthalmologists involved in the project have reported "visual improvement" in 92.4% of patients, LeBlanc perpetuates the misapprehension that visual acuity as reported by the surgeon is a better measure of visual function than the VF-14 as reported by the patient and as used in our study. We agree that the question he suggests for determining patient satisfaction would be a good one in any evaluation of elective surgical outcomes. For example, it could be added as a final question in the postoperative application of the VF-14 questionnaire.

The reported results were restricted to patients undergoing first-eye surgery because the steering committee was uncertain how to deal with the 1-eye or 2-eye issue raised by Bellan, and current practice varies widely in relation to indications for and timing of surgery on the second eye. Bellan seems to be arguing for routinely operating on both eyes, but we must leave this question (for patients with or without mild cataract in the second eye or postoperative anisometropia) to be answered by ophthalmologists on the basis of research evidence.

Finally, we did not suggest that the VF-14 should be used with some kind of absolute threshold as the sole criterion of the need for surgery. As with any operation, the recommendation to proceed

must be based on careful assessment of symptoms, functional impairment and findings in relation to the potential benefits and risks of the procedure. Surgery may indeed be indicated in some patients with minor visual impairment, but our conclusion that "the threshold indications for cataract surgery are now very low" remains valid (and is probably an understatement) on the basis of the evidence we obtained from the best instrument currently available.

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Reference

1. Wright CJ, Chambers GK, Robens-Paradise Y. Evaluation of indications for and outcomes of elective surgery. *CMAJ* 2002;167(5):461-6.

Neuroimaging misinformation

Publicizing the serious risks of traumatic dissection causing vertebrobasilar stroke, as Malvinder Parmar did recently,[1] is essential to limit any associated risks, especially those that might result from vigorous chiropractic manipulation. However, the CT image published with Parmar's letter[1] damages the credibility of documented information on this condition. The image shows the suprasellar cisterns and the upper pons, distant from the vertebral arteries. Specifically, the white arrow shows low density, indicating infarction in the right pons, and the black arrow shows the right suprasellar cisterns. The density between the anterior and posterior clinoids is typical for ossification of the dura connecting the clinoids. Calcification of the internal carotid is less likely. The scan slice does not show the vertebral artery, an editorial mistake as serious as labelling a knee "foot."

Another error concerns the mention of calcification of the right vertebral artery. Calcification would not cause pontine infarction. Rather, it is an epiphenomenon of atherosclerotic disease. There is also no specific propensity for ipsilateral vertebral dissection to cause ipsilateral pontine stroke. Dissection of either vertebral artery can cause ipsilateral or contralateral infarction. Only infarction of the posterior inferior cerebellar artery is side specific.

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Reference

1. Parmar MS. Telephone stroke [letter]. *CMAJ* 2002;167(10):1104.

[The author responds:]

I thank Allan Fox for his comments and agree that the CT slice published with my earlier letter[1] does not show the calcified right vertebral artery. Rather, it shows calcification in the sellar area. Although the CT image selected for publication did not show the right vertebral artery, the reporting radiologist clearly identified calcification of this vessel in a different slice (Fig. 1). Because of space limitations, only one slice, showing both calcification and the infarct, was selected for publication. Unfortunately, the wrong caption was included with the image, for which I sincerely apologize.

I also agree that the calcium deposit was an epiphenomenon that did not cause the stroke. However, I did not claim that the calcium deposit was the culprit. Rather, I merely speculated that occlusion of the right vertebral vessels caused by abnormal positioning of the neck during a prolonged telephone conversation probably led to thrombosis in the vertebral vessels, which in turn led to embolization of the clot and ultimately the pontine stroke.

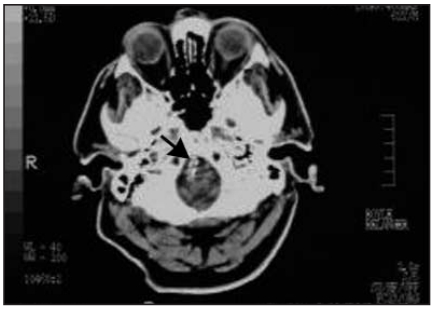

Fig. 1: CT of the head, showing calcification of the right vertebral artery (black arrow).

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Reference

1. Parmar MS. Telephone stroke [letter]. *CMAJ* 2002;167(10):1104.

Corrections

The following corrections to the *CMAJ* supplement containing the 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada[1] should be noted. In the section on vitamin K (page S19), "menatetrone" should be spelled "menatetrenone." In the third paragraph of the section on parathyroid hormone (page S21), "20 or 40 mg/day injected subcutaneously" should read "20 or 40 µg/day injected subcutaneously." Summary statement 57a should read "men and women aged 19-50 years …" (page S23).

Reference

1. Brown JP, Josse RG, for the Scientific Advisory Council of the Osteoporosis Society of Canada. 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada. *CMAJ* 2002;167(10 Suppl):S1-S34.

In a Jan. 21 article on mercury poisoning,[1] an error occurred in the unit of measure. The blood mercury levels indicated in the second paragraph are 176 and 209 µg/L, respectively. The units are listed incorrectly as µmol/L.

Reference

1. Weinstein M, Bernstein S. Pink ladies: mercury poisoning in twin girls. *CMAJ* 2003;168(2):201.

Immunity to Norwalk-like viruses was incorrectly stated to be 14 days in a recent Public Health article.[1] Immunity in fact lasts up to 14 weeks.

Reference

1. Chris A. Norwalk-like viruses: When the runs can slow you down. *CMAJ* 2003;168(1):64-5.