will be referred to the MCC Executive Board at its meeting in October 2003.

We expect that this example and other "disconnects" in licensure and immigration policies of the "federation of partners" will be studied, so that when the anticipated recommendations of the task force are made public, they can be acted upon by the MCC and other bodies in a coordinated and timely manner.

W.D. Dauphinee
Executive Director
Medical Council of Canada
Ottawa, Ont.

Reference

1. *Information pamphlet on the Medical Council of Canada evaluating examination (MCCEE) 2003.* Ottawa: Medical Council of Canada; 2003. Available: www.mcc.ca/pdf/PamphletENG.pdf (accessed 2003 Oct 7).

A university's name

In contrast to the information in Table 1 of Patrick Sullivan's article about medical students' debt on graduation,[1] the correct name for our university is Memorial University of Newfoundland.

June Harris
Associate Professor of Anatomy
Director, MedCAREERS
Faculty of Medicine
Memorial University of Newfoundland
St. John's, Nfld.

Reference

1. Sullivan P. Mortgage-sized debt the new normal for medical students. *CMAJ* 2003;169(5):457-8.

SARS in health care workers

I wondered if Monica Avendano and associates[1] were planning a follow-up report on the 14 health care workers who were treated for severe acute respiratory syndrome (SARS) at the West Park Healthcare Centre. At the time of publication of that report, all of the patients had recovered sufficiently to go home, but only one had returned to work.

I am interested and concerned as to how these patients have progressed in the past few months.

Gordon Farrow
Tax Accountant
Scarborough, Ont.

Reference

1. Avendano M, Derkach P, Swan S. Clinical course and management of SARS in health care workers in Toronto: a case series. *CMAJ* 2003; 168(13):1649-60.

[The authors respond:]

We have continued to follow the patients described in our article[1] after their discharge from the SARS unit. They have undergone chest radiography, pulmonary function testing, chest CT, sleep studies and graded exercise tests. By the eighth week after discharge, the results of chest radiography were normal for all patients. However, CT of the chest showed abnormalities in some patients for up to 6 months after discharge. Convalescent serum antibody tests have been performed for all patients, but the results are not yet available.

Most of the patients have returned to work, the initial group going back 2 months after the onset of acute illness. Fatigue, dyspnea on exertion and insomnia are the most common persisting symptoms. Most of the patients have demonstrated symptoms indicative of the psychological impact of SARS. We are planning a follow-up review for next spring, 1 year after the onset of illness.

Monica Avendano
Peter Derkach
Susan Swan
West Park Healthcare Centre
Toronto, Ont.

Reference

1. Avendano M, Derkach P, Swan S. Clinical course and management of SARS in health care workers in Toronto: a case series. *CMAJ* 2003; 168(13):1649-60.

Ziprasidone — not an option for serotonin syndrome

A recent article concerning serotonin syndrome[1] contained an inaccuracy that might result in clinicians attempting a misguided, if not fatal, treatment option. While correctly noting the presumed role of 5-HT_{1A} receptor activation in the pathophysiology of the syndrome, the authors twice surmise that ziprasidone, an atypical antipsychotic, might warrant study as a therapeutic option because of its potent blockade of 5-HT_{1A} receptors.

The reference that the authors use as the pharmacologic basis for this assertion does acknowledge the potent binding of ziprasidone at the 5-HT_{1A} receptor;[2] however, the high affinity of the drug for this receptor is as an agonist, not as an antagonist.[3,4] Other effects of ziprasidone on the serotonergic system include potent antagonism of 5-HT_{1D}, 5-HT_{2A} and 5-HT_{2C} receptors, as well as moderate inhibition of serotonin reuptake.[3,4]

The net result of ziprasidone on serotonergic neurotransmission makes it an inappropriate candidate for treating serotonin syndrome. Aside from the overt problem of directly stimulating 5-HT_{1A} receptors, there is also the more subtle, yet still concerning, matter of indirectly stimulating these same receptors via antagonism of 5-HT_{2A} receptors and inhibition of serotonin reuptake. In fact, there have been reported cases of serotonin syndrome precipitated by the use of other atypical antipsychotics, which are also 5-HT_{2A} receptor antagonists, in combination with serotonergic drugs.[5]

Thus, the use of ziprasidone for treatment of serotonin syndrome seems ill-advised and could prolong or worsen the patient's symptoms. In cases in which the clinician seeks treatment with serotonin antagonists, purported options include methysergide, cyproheptadine and propranolol.[6]

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