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DOI:10.1503/cmaj.1040701

TB and adrenal insufficiency

Ronik Kanani and Aleixo Muise¹ describe a case of intra-abdominal peritonitis associated with abdominal pain and hypotension secondary to intra-abdominal tuberculosis (TB). The clinical presentation in this case is suspicious for adrenal insufficiency.

TB is one of the leading causes of adrenal insufficiency worldwide, but the presence of TB may be difficult to diagnose. In a large retrospective study of autopsy results in Hong Kong, Lam and Lo² found active TB in 6.5% of cases; however, in more than 70% of these patients, TB was diagnosed only at autopsy. Adrenal insufficiency was found in 6% of the patients with active TB.

It may also be difficult to identify TB as the cause of adrenal insufficiency, as illustrated by Serter and associates.³

These authors described a 61-year-old man with adrenal insufficiency and an adrenal mass. The results of tuberculin skin testing, staining for acid-fast bacilli and culture were all negative; only histologic examination after adrenalectomy confirmed the diagnosis of TB.

In patients presenting with shock and risk factors for TB it is important to maintain a high index of suspicion for adrenal insufficiency. When in doubt, administration of a stress dose of steroids while awaiting the results of corticotropin (ACTH) and cortisol measurement may save the patient's life.

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DOI:10.1503/cmaj.1041046

[The authors respond:]

Although TB is one of the leading causes of adrenal insufficiency in the world and should be considered in patients presenting with shock and a history suggestive of TB,¹ the index of suspicion for adrenal insufficiency was quite low in the case that we reported.² Although the patient was initially hypotensive, his blood pressure did respond to fluid administration, and his electrolyte levels were initially normal. In contrast, patients in adrenal crisis usually require steroid treatment and do not respond readily to fluids. Furthermore, the patient underwent multiple CT examinations of the abdomen, all of which showed that the adrenal glands were normal. We did not check the patient's cortisol level, nor did we do corticotropin stimulation test, as it was extremely unlikely that the patient had

adrenal insufficiency. Nonetheless, we thank Wael Haddara and Stan van Uum for describing this important point.

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DOI:10.1503/cmaj.1041257

Privacy of pharmacy prescription records

On behalf of the National Association of Pharmacy Regulatory Authorities (NAPRA), Canada's voluntary umbrella association of provincial and

territorial pharmacy regulatory bodies, I am writing to respond to the commentary by Dick Zoutman and associates¹ about pharmacy prescription records.

The statement in that commentary that "patient identifiers . . . stream from pharmacy computers via commercial compilers to pharmaceutical companies" is incorrect, and there is no basis for the broad allegation that patient information has been improperly disclosed from pharmacies. The authors state that they "are unaware of a PIPEDA- [Personal Information Protection and Electronics Documents Act] based challenge to the selling of patient information by Canadian pharmacies." The simple reason why they are unaware of any challenge is that such disclosure does not occur.

The personal health information of patients ("patient information") and professional practice information about physicians ("physician-linked prescrip-

tion information") are not equivalent. Patients' health information is personal information about the patient and deserving of the highest level of protection the privacy legislation can confer. However, physician-linked prescription information is not personal information under PIPEDA and is afforded no such protection. This situation has been confirmed in a decision of the Privacy Commission of Canada.²

The legislative mandate of pharmacy licensing bodies is to protect the health and safety of the public, not to protect the interests of health care providers, including pharmacists. Although requirements, standards and guidelines for the practice of pharmacy may vary at the provincial level — because each province has its own legislation in this area — the requirement for patient consent for the disclosure of identifiable patient information (absent a legal exception) is universal. As of January 2004, PIPEDA applied to pharmacies