tween low bone mineral density (BMD) and fracture risk in postmenopausal women,[2,3] and the risk increases with age for a given level of BMD.[4,5] This predictive ability of BMD for fractures is greater than that of blood pressure for stroke and cholesterol level for cardiovascular disease.[2] However, in younger postmenopausal women with low BMD, the absolute risk is low.[4] Therefore, on the basis of the absolute fracture risk, we recommend BMD screening by DEXA for all postmenopausal women starting at age 65 (see Fig. 1 in our original article[1]). If the result of the initial DEXA is normal, we recommend repeating this test in 2 years. On the same basis, we also recommend considering pharmacologic treatment for those over age 65 with *T* scores between –2.0 to –2.5. Those younger than 65 years of age with *T* scores above –2.0 have a lower absolute risk of fracture and therefore the corresponding number needed to treat to prevent one fracture is higher.

In our statement,[1] we were explicit that these recommendations do not apply to those in nursing homes, because we limited our systematic review to the community-dwelling population. We did review compounds that were not available in Canada at the time of our submission for publication but for which published evidence was available (e.g., teriparatide and oral pamidronate), as they may become available here sometime in the future. Current evidence suggests that pharmacologic therapies can further reduce fractures in osteoporotic postmenopausal women who are receiving adequate amounts of vitamin D and calcium. Although we recommend regular exercise because it can maintain BMD and reduce falls, no good evidence exists for fracture reduction with regular exercise in this population.

These evidence-based clinical guidelines are meant to guide physicians in discussions with their postmenopausal patients, as each individual woman may have unique risks and preferences. The guidelines need to be interpreted and applied sensibly. In general, clinical practice guidelines are designed to hasten the incorporation of research findings into routine care, but they are usually not the reference for medicolegal action. Most common law rulings in North America and the United Kingdom are based on minimum acceptable standards of clinical care, which are often derived from responsible customary practice, rather than from clinical practice guidelines.[6,7]

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Mapping malaria

Congratulations to Kathryn Suh and colleagues[1] for their recent comprehensive review of malaria. I have 2 corrections for their Fig. 1, the map showing global distribution of malaria. First, malaria is not endemic to Uruguay. Second, in Paraguay, malaria is in fact sensitive (not resistant) to chloroquine.

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[The authors respond:]

We thank Tomás Orduna for bringing to our attention some inaccuracies in the map illustrating the global distribution of malaria, which appeared in our review article on this disease.[1] He is correct in pointing out that there is no risk of malaria in Uruguay and that only chloroquine-sensitive malaria is present in Paraguay.

As noted in the original figure caption, the map was intended as a visual aid only and was not meant to provide definitive recommendations regarding malaria risk and prophylaxis. Furthermore, malaria risk may vary within a given country, and hence not all travellers to that country will necessarily require malaria prophylaxis. Readers are therefore referred to additional travel medicine resources, such as Health Canada, the US Centers for Disease Control and Prevention and the World Health Organization (as suggested in the original figure caption and listed at the end of our article[1]), for current recommendations regarding country-specific malaria risks and recommended prophlyaxis.

Our Fig. 1 was published courtesy of Health Canada's Committee to Advise on Tropical Medicine and Travel