

tween low bone mineral density (BMD) and fracture risk in postmenopausal women,<sup>2,3</sup> and the risk increases with age for a given level of BMD.<sup>4,5</sup> This predictive ability of BMD for fractures is greater than that of blood pressure for stroke and cholesterol level for cardiovascular disease.<sup>2</sup> However, in younger postmenopausal women with low BMD, the absolute risk is low.<sup>4</sup> 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<sup>1</sup>). 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,<sup>1</sup> 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 find-

ings 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.<sup>6,7</sup>

The Canadian Task Force for Preventive Health Care is funded through Health Canada and strives to provide up-to-date, unbiased guidelines for primary care physicians in Canada. No drug company was involved financially or otherwise in this recommendation statement.

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## Mapping malaria

Congratulations to Kathryn Suh and colleagues<sup>1</sup> 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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- Suh KN, Kain KC, Keystone JS. Malaria. *CMAJ* 2004;170(11):1693-702.

*Competing interests:* None declared.

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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.<sup>1</sup> 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<sup>1</sup>), for current recommendations regarding country-specific malaria risks and recommended prophylaxis.

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

(CATMAT),<sup>2</sup> and the Committee has now been made aware of these errors.

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## To self-cite or not to self-cite

The article by Apoor Gami and associates<sup>1</sup> on self-citation in the diabetes literature included 1 self-citation (out of a total of 9 references), which involved 3 of the study's authors (reference 6 in the original article). Thus, self-citations constituted 11% of the article's citations, which is more than the reported mean of 18% and median of 7%.

We agree that this phenomenon is prevalent in the literature. We, too, have published articles with self-citations.<sup>2,3</sup> In fact, this letter now has a self-citation rate of 66%!

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## [Three of the authors respond:]

Raheem Kherani and Michelle Fung note that we referenced one of our own publications in our recent article about self-citation.<sup>1</sup> In fact, we acknowledged this (in the second paragraph of the Interpretation section of that article), as an example of the necessity or utility of self-citation. However, Kherani and Fung have calculated the rate of self-citation incorrectly. Author self-citations, as described in our article, are subsequent citations to an article by one of its authors. Thus, our citation of the paper by Montori and colleagues<sup>2</sup> raised the self-citation count of that article by 1, but it did not affect the citation count of our present article.<sup>1</sup> Calculating the proportion of self-citations to the latter would involve dividing the number of our subsequent publications that cite it by the total number of subsequent publications that cite it.

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## How children see themselves

In their recent research letter, Gail McVey and associates<sup>1</sup> suggest that fear of being overweight and the desire to be thinner lead to behaviours such as "dieting and other extreme weight control methods." Their proposed solution is to increase the education of key individuals, including primary care physicians.

In designing a prevention program, it is important to realize that teenagers' fear of becoming overweight is reasonable. Given the significant social discrimination against obese individuals in areas such as marriage, income, health care and education,<sup>2,3</sup> as well as the rise in obesity among children and teens,<sup>4,5</sup> it is not surprising that some teens go to great lengths to prevent weight gain.

It would have been useful if the authors had reported how many respondents in their sample were aware that their eating behaviour was inappropriate. Such awareness has a great bearing on what preventive measures will be effective. In particular, it would be helpful to determine how a physician should manage care for a girl at serious risk of obesity if dieting is not an option.

In most people, dieting and disordered eating are symptoms of the underlying issue of body dissatisfaction. It is not clear how effective educational prevention programs will be in addressing this problem. However, it seems advisable to determine the overall impact of such interventions (including any possible adverse outcomes) before recommending this approach to primary care physicians.

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