were surprised by the low use of ACE inhibitors or equivalent for patients who had diabetes but no clinical evidence of CAD.

These preliminary results indicate that there is room for improvement in implementing treatment guidelines in clinical practice. The overall use of cardioprotective medications was suboptimal at the initial visit, although use had increased significantly by the time of the most recent visit (Table 1). However, the use of ACE inhibitors remained suboptimal among diabetic patients without CAD, a result similar to the data presented by Brown and associates.[1] We agree that multidisciplinary cardiovascular risk reduction programs are needed to improve quality of care in high-risk patients.

Miriam Shanks
University of Alberta Hospital
Edmonton, Alta.
Daniel T. Holmes
Luba Cermakova
Jiri Frohlich
Lipid/Cardiovascular Risk Reduction Clinic
St. Paul's Hospital
Vancouver, BC

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C. difficile: Will lessons be learned?

Laura Eggertson[1] reports that "there were 7004 cases of [*Clostridium*] *difficile* across Quebec from Apr. 1, 2003, to Mar. 31, 2004, and 1270 people died." Additional data in her article reveal a staggering increase in both morbidity and mortality due to *C. difficile* from 2001 to 2003,[1] yet the provincial government only recently intervened with policies to aggressively control the outbreak. Moreover, some health care professionals have reported a lack of sufficient resources to effectively control the outbreak.[2] This state of affairs raises 2 issues: first, how health care institutions effectively intervene when a pathogen manifests in a community and, second, the allocation of resources to achieve desired social goals.

The fact that, until recently, reporting of hospital-acquired infections to health care authorities was not required points to both structural and procedural shortcomings within our health care institutions. The recent establishment of province-wide surveillance and infection-control committees is intended to rectify the structural deficiencies, although the effectiveness of these measures remains unknown. In addition, procedural interventions appear to have been underused, both clinically and interpersonally. Clinically, health care professionals should have been informed by a provincial nosocomial infection control committee about the technical means of controlling the outbreak. This advice should have been based on the best evidence available and should have been provided as soon as possible after the increase in incidence was noted.[3–5] At an interpersonal level, patients or their representatives should have been informed of the increased risks and patient groups should have been engaged in consultation and decision-making.

Yet these structural and procedural interventions cannot be undertaken without the addition of the resources needed for their implementation. If hospitals have to redirect existing scarce resources from other services to combat *C. difficile*, overall quality of care could decline.

But the saddest lesson from the *C. difficile* outbreak has been exposure of the lack of planning and coordination in the face of a virulent form of a known infection. I hope the lessons of the *C. difficile* epidemic serve as a grave warning in case of future outbreaks of new pathogens.

Joseph Erban
Member
Clinical Ethics Committee
Sir Mortimer B. Davis – Jewish General Hospital
Montréal, Que.

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Influenza vaccine for all?

I find it interesting that, a few weeks after celebrating the achievements of the Cochrane Collaboration,[1] *CMAJ* published a systematic review[2] and a recommendation statement from the

Canadian Task Force on Preventive Health Care[3] on preventing influenza in the general population (and the authors of the systematic review were quoted in the lay press as endorsing universal vaccination[4]), when a Cochrane review of the topic[5] already exists.

The Cochrane systematic review,[5] alluded to but not cited by Joanne Langley and Marie Faughnan,[2] concludes that "[i]nfluenza vaccines are effective in reducing serologically confirmed cases of influenza. However, they are not as effective in reducing cases of clinical influenza and number of working days lost. Universal immunisation of healthy adults is not supported by the results of this review."

Langley and Faughnan[2] state that their goal was to determine the efficacy of the vaccine, not the efficacy of a universal vaccination program. Yet it appears that they, and the task force, endorse such a strategy, without evidence related to a variety of ancillary considerations that they identify (including economic costs, vaccine procurement and public acceptability).

Something is missing here. Was the *CMAJ* systematic review not the compelling piece of evidence leading to the task force's endorsement of universal vaccination? Was the conclusion of the Cochrane Collaboration wrong? Is there evidence of cost-effectiveness, and have procurement issues been sorted out? Just how many systematic reviews do we need on a particular topic?

R.A. Fisher, the pioneering methodologist for randomized trials and the most influential statistician of the 20th century,[6] envisioned controlled trials (and, by extension, systematic reviews and meta-analyses) as an essential technique to reduce the interpretive variability of study results. I wish he and Archie Cochrane were still around to help us sort this out.

Ross Upshur
Department of Family and Community Medicine
Sunnybrook and Women's College Health Sciences Centre
Toronto, Ont.

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[One of the authors and the chair of the CTFPHC respond:]

As systematic reviews and meta-analyses have become established as methods for evidence-based decision-making, reviews on similar questions have been published, sometimes with discordant results. Recommended approaches to reconciling these differences include determining if the results truly differ or if the variation arises from the interpretation of the results.[1] Ross Upshur notes that different conclusions on vaccination of the general public were reached by the Canadian Task Force on Preventive Health Care (CTFPHC)[2,3] and the Cochrane Collaboration.[4] In this case, the reviews covered different populations (healthy adults and children in the CTFPHC review, healthy adults only in the Cochrane review) and considered different interventions (vaccines and neuraminidase inhibitors in the CTFPHC review, vaccines only in the Cochrane review). There were also differences in methods: CTFPHC reviews are systematic qualitative reviews,[5,6] whereas the Cochrane reviews are generally quantitative reviews.[4,7] As noted in the Methods section and Fig. 1 of our review,[2] we reviewed the Cochrane database to find primary trials that might not have been identified in our literature search. The trials that