stating that this man had emigrated from an area where tuberculosis is prevalent? Would the public health implications have been any less significant had the subject been referred to as a “health care professional working in the neonatal intensive care unit?”

I presume that the physician described in this report gave written consent (as is CMAJ’s policy for such matters). Even so, I see no reason why his identity had to be made so transparent.

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REFERENCE
DOI:10.1503/cmaj.1050211

[Editor’s note:] It is possible that the editors requested for additional details that were not included in the published version of the article because of confidentiality concerns. We take full responsibility for our work; perhaps we erred in supplying any of the details that the editors requested.

Mithu Sen
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DOI:10.1503/cmaj.1050211

A painful elbow?

May I suggest the patient consult a real doctor, since the condition appears to be bilateral (text v. picture).1

James Battershill
Retired Physician Vancouver, BC

REFERENCE

Measuring the presence of chronic diseases

It is interesting that the time when patients were evaluated using the Charlson Comorbidity Index was not mentioned in the study by Pepin and colleagues.1 It is possible that Clostridium difficile infections occurred in patients who were in a more serious condition; evaluation of the baseline characteristics of the 2 patient groups would have been best done 48 to 72 hours before the diagnosis of C. difficile-associated disease (CDAD) was made.

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REFERENCE
DOI:10.1503/cmaj.1050136

[One of the authors responds:] The Charlson Comorbidity Index measures the presence of chronic diseases, and we used diagnoses listed in the discharge summaries of current and prior hospital admissions. For conditions such as ischemic heart disease, peripheral vascular disease, diabetes, chronic obstructive lung disease, dementia and the like, we feel that the exact timing of