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.

Steven L. Shumak
Division of General Internal Medicine
University of Toronto
Toronto, Ont.

REFERENCE

1. Sen M, Gregson D, Lewis J. Neonatal exposure to active pulmonary tuberculosis in a health care professional. *CMAJ* 2005;172:1453-6.

DOI:10.1503/cmaj.1050144

[The authors respond:]

We thank Steven Shumak for his insightful comments concerning our recent case report in *CMAJ*.[1] Many of the details in the article concerning the index case were requested during the editorial review process. Indeed, the editors asked 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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Daniel Gregson
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University of Western Ontario
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REFERENCE

1. Sen M, Gregson D, Lewis J. Neonatal exposure to active pulmonary tuberculosis in a health care professional. *CMAJ* 2005;172:1453-6.

DOI:10.1503/cmaj.1050211

[Editor's note:]

It is difficult to completely conceal the identity of an individual in a case report unless he or she has a common disease with a common presentation. In this report of exposure of neonates, staff and visitors in an intensive care unit it was important to describe the index case, the resident and his background, previous exposure to tuberculosis and dates of his chest x-rays during the immigration process. Because of the authors' affiliations, the identity of the intensive care unit could not be concealed. Also, because of the large number of people involved in the investigation of possible tuberculosis, it is likely that the identity of the index case was known.

John Hoey
Editor
CMAJ

DOI:10.1503/cmaj.060066

Reporting communicable diseases

Although the article on dermatologic emergencies[1] was directed primarily at the clinical management of the presenting patient, I noted that there was no mention of the fact that cases of staphylococcal toxic shock syndrome, necrotizing fasciitis, and invasive *Neisseria* meningitis infections should be reported to the medical officer of health.

I would encourage *CMAJ* to attempt to include reporting to public health as one aspect of the management of any of the generally recognized "reportable communicable diseases" throughout Canada, as this one step in treatment may sometimes be overlooked by our acute care colleagues.

Isaac Sobol
Chief Medical Officer of Health
Nunavut

REFERENCE

1. Freiman A, Borsuk D, Sasseville D. Dermatologic emergencies. *CMAJ* 2005;173(11):1317-9.

DOI:10.1503/cmaj.1050270

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

1. Shu DH, Shu AC, Yuen M, et al. A case of painful elbow: What's your diagnosis? *CMAJ* 2005;173(12):1445-6.

DOI:10.1503/cmaj.1060003

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.

Wenbin Liang
School of Public Health
Curtin University of Technology
Perth, Australia

REFERENCE

1. Pépin J, Valiquette L, Cossette B. Mortality attributable to nosocomial *Clostridium difficile*-associated disease during an epidemic caused by a hypervirulent strain in Quebec. *CMAJ* 2005;173(9):1037-42.

DOI:10.1503/cmaj.1050236

[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

their measure relative to the diagnosis of CDAD is immaterial.

Jacques Pépin
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DOI:10.1503/cmaj.1050257

Canadian Healing Oil

I was interested in the photo of Canadian Healing Oil and the accompanying caption in a recent edition of The Left Atrium.[1] I grew up in the Caribbean and can attest to the fact that Canadian Healing Oil was an essential component of the home medicine cabinet. It was administered to me for all of the indications described on the bottle label. I had to take it orally and via steam inhalation; it was also used as ear drops to remove wax and relieve earaches. I had assumed that the product included some kind of oil from Canadian pine trees, but it appears that the only uniquely Canadian ingredient is sulphonated seal oil.

Canadian Healing Oil was a soothing balm for us in the Caribbean; perhaps its effect is comparable to the soothing effect of Caribbean rum on the Canadian psyche. Both products must be used prudently, of course.

J.M. Dubé
Retired Family Physician
Nanaimo, BC

REFERENCE

1. Hanlon V. Canadian Healing Oil. *CMAJ* 2005;173 (9):1073.

DOI:10.1503/cmaj.1050233

Is this clinical trial fully registered?

In September 2004, the International Committee of Medical Journal Editors (ICMJE) proposed a specific registration for clinical trials whose authors expect consideration for publication.[1] Registration of clinical trials is an important issue. However, we felt uncomfortable with this proposal. Indeed, the ICMJE definition of clinical trial was quite ambiguous and ICMJE criteria excluded already mandatory registrations (i.e., European Medicines Agency).[2] Now, registration of any clinical trial to be submitted for publication is mandatory, and the ICMJE states "each journal editor will decide on a case-by-case basis about reviewing unregistered trials."[3] This new rule for manuscript evaluation lacks transparency, transparency which was an end of this registration proposal. Last, no evaluation of this policy is planned.

The key to improving knowledge and the quality of trials is not to inflate regulations and guidelines, but rather to enforce already existing ones. For example, editors should endorse and implement the CONSORT (Consolidated Standards of Reporting Trials) statement, which gives recommendations for reporting randomized controlled trials. Only 22% of high-impact medical journals refer to CONSORT in their advice to authors, but many use ambiguous language regarding what is expected or fail to cite the up-to-date version.[4] Please, no more clerical burden for the clinical investigator!

Alain Braillon
Gérard Dubois
Service d'évaluation médicale, CHU
Amiens, France

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1. De Angelis CD, Drazen JM, Frizelle FA, et al. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. *CMAJ* 2004; 171(6): 606-7.
2. Braillon A, Dubois G, Slama M. Registration of clinical trials [letter]. *Ann Intern Med* 2005;142(3): 228.
3. De Angelis CD, Drazen JM, Frizelle FA, et al. Is this clinical trial fully registered? A statement from the International Committee of Medical Journal Editors. *CMAJ* 2005;172:1700-2.
4. Altman DG. Endorsement of the CONSORT statement by high impact medical journals: survey of instructions for authors. *BMJ* 2005;330:1056-7.

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DOI:10.1503/cmaj.1060012

[The Editor in Chief responds:]

Alain Braillon and Gérard Dubois ask some important questions.

The ICMJE definition of a clinical trial could not take into account the (multiple) definitions of clinical trials used by various registries. We were interested in capturing clinical trials that were likely to contain information relevant to clinical practice. The problem of definition is most acute for very early clinical trials, often referred to as Phase 2 trials, whose purpose can be to determine recruitment strategies, compliance, frequencies of primary outcomes and the like. These trials are not intended to provide meaningful outcomes that can be used to guide clinical or preventive practice. Although other national registries, such as the European Medicines Agency, may require these types of trials to be registered, the ICMJE does not. Obviously, the ICMJE is supportive of more inclusive registries.

Case-by-case consideration was added for several reasons, but chief among them was the vagueness of the definition of an eligible Phase 2 trial. We recognized that some Phase 2 trials, designed to help plan Phase 3 trials (and thus not in need of registration according to the ICMJE definition) might yield unanticipated information and results that had clinical applicability, such as an unexpected efficacious result or serious adverse events. Also, there was bound to be some failure to register, possibly among trialists from small centres or parts of the world that are not aware of the deadlines. We are reasonable bunch, and we are trying to be transparent.

We welcome efforts to evaluate the policy and expect that journalogists and others will be looking for results and tracking progress. We very much encourage groups such as yours to undertake this type of study.

Lastly, I agree that editors should do better at encouraging authors of accepted papers to use the CONSORT guidelines.

John Hoey
Editor in Chief
CMAJ

Competing interests: I am a coauthor of the ICMJE statement on clinical trials registration and editor of a journal that supports efforts to publicly register clinical trials.

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