



Homeless shelters and substance misuse

We read with interest Wendy Muckle and Jeffrey Turnbull's guest editorial on homelessness.¹ Although shelters are not perfect, they do protect people from some aspects of homelessness. For example, there is evidence of cognitive impairment in some homeless people,² and this association is partially dependent on housing quality.³

We compared substance misuse in 31 homeless people staying in supportive shelters with that in 15 people who were literally roofless in Sheffield in the United Kingdom. Thirteen (87%) of the roofless people had injected drugs in the past month compared with only 4 (13%) of the people in shelters. All 15 (100%) of the roofless people had been using heroin or crack cocaine regularly in the past year compared with only 10 (32%) of the people living in shelters.

Homelessness is inevitably harmful and can become self-perpetuating. In our study, despite the lower level of drug use in people living in shelters, 18 (58%) of the people in this group had started taking at least 1 new drug since becoming homeless. If the homeless do not receive significant levels of help, the problems they experience can multiply. A public policy of increasing resources to address the problems of the homeless would likely be highly cost-effective over the longer term. Muckle and Turnbull are right to be concerned about the possibility of cut-

backs by the current Canadian government to the homelessness funding program.

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DOI:10.1503/cmaj.106022g

Family practitioners and the Canadian Diabetes Association

I recently attended the national Canadian Diabetes Association (CDA) conference in Toronto. The conference was attended by a host of professionals and lay people from various walks of life, but family physicians were not well represented. Where were my fellow family physicians with a special interest in diabetes management?

At conferences and continuing medical education events, speakers often make disparaging remarks about mistakes or oversights by family physicians. Everybody seems to be busy compiling treatment guidelines to get those overworked and rusty old family physicians back in line.

I believe that family physicians with a special interest in caring for patients with diabetes mellitus should create a separate group under the auspices of the CDA. The group would hold its own meetings where members could share their knowledge and experience, participate in continuing medical edu-

cation, share their research findings in a constructive environment and set standards of care for family practice that we can all strive to meet. Such a group could also lobby on behalf of family practitioners for better remuneration for time spent in attending to patients with diabetes. Attendance at the CDA conference and at the meetings of the family physicians' group would be requirements of membership in the "club," with advantages, such as increased remuneration, flowing back to the members of the group. As family physicians we must take control once again of the ongoing care of our patients with diabetes. I welcome responses to this proposal (drsnymn 2003@yahoo.com).

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DOI:10.1503/cmaj.106022t

Cardiac risks with COX-2 inhibitors

Linda Levesque and colleagues' findings concerning the timing of cardiovascular risks in elderly users of cyclooxygenase-2 (COX-2) inhibitors are interesting,¹ but they might reflect the superiority of rofecoxib over other agents as an analgesic and anti-inflammatory agent rather than any specific cardiotoxic effect of this drug. The peak in the risk of cardiac events in the second week of treatment with rofecoxib might simply be related to increased activity levels in patients who had previously been in pain and who therefore had probably been less active and had experienced a decline in physical fitness. With a half-life of 24 hours, it takes 6 half-lives (about a week) for rofecoxib to reach steady state and maximal sustained efficacy. The finding that cardiac risk dropped back toward baseline after the second week could be explained by the patients' improved cardiac fitness result-