that treat Medicare patients in the United States. These efforts have been highly effective.

Although the Canadian Council for Donation and Transplantation has made some efforts, there has not been a significant increase in organ donation rates in Canada and our organ donation system is still fragmented. Although there are different provincial health jurisdictions in Canada, we do have universal health services in this country, which provide a platform for collaboration between the provinces and territories. I believe that people's generosity and altruism will eventually overcome the barriers between jurisdictions.

A national centre for donation and transplantation would be able to oversee all aspects of transplantation in Canada, could work to gain the public's trust in allocating organs and could communicate efficiently with authorities in each province and terrority. We need a major "transplantation" in Canada if we want to match the success of the US United Network for Organ Sharing.

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DOI:10.1503/cmaj.1060230

[The author responds:]

The points made in the letter from David Hollomby and colleagues are ones made by Ms. Young in the original News article.[1] Dr. Martin takes issue with the notion that Canada lacks a national registry or mechanism for allocating organs, similar to the United Network for Organ Sharing, and argues that the existing informal arrangement for allocating livers, albeit underfunded, operates to tackle ways to optimize liver allocation and transplant outcomes. The News article did not suggest otherwise and it certainly does not state that organ sharing is somehow an afterthought. On the contrary, it stated that there is limited sharing within programs. It also noted that the liver community may soon adopt a more formal allocation system that gives preference to urgent cases under a status system.

Both of these letter writers argued for a quintessential made-in-Canada system to "reflect our reality," as Dr. Martin so eloquently put it. As the News article made clear, neither should be concerned on that score. Such a unique system is already here.

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DOI:10.1503/cmaj.1060223

Auspitz sign-off

I read with interest the Clinical Vistas Brief by Ahmad Ayaz Sabri and Muhammad Ahad Qayyum.[1] Papillary bleeding upon removal of psoriatic scales has been called the Auspitz sign, but the phenomenon was described by several authors before Auspitz, namely, Hebra, Turner, Willan and Plenck.[2] Bernhard showed this sign to lack sensitivity (only 41 of 234 patients with psoriasis exhibited the sign) and specificity for psoriasis (a similar phenomenon could be observed with many non-psoriatic lesions).[3] Although the Auspitz sign stubbornly persists in many textbooks, it most likely should not be used as a modern diagnostic tool.

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DOI:10.1503/cmaj.1060164

[The authors respond:]

CMAJ's Clinical Vistas Briefs are presented as short diagnostic quizzes de-

signed to sharpen clinicians' visual recognition skills.[1] The case of psoriasis that we submitted to the Briefs column[2] was diagnosed after the patient provided a complete history and underwent a physical examination. During the examination, we found the Auspitz sign in this patient, but we did not say in our Brief that this sign is specific or sensitive for psoriasis. With regard to the controversy about the discoverer of the Auspitz sign, it is up to the medical historians to find out the truth so that the appropriate person may be honoured.

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DOI:10.1503/cmaj.1060237

Uninsured patients undergoing dialysis in Greece

We agree with Paul Caulford and Yasmin Vali that uninsured immigrant and refugee patients are undertreated.[1] In Greece, uninsured patients with end-stage renal disease cannot be registered to undergo regular hemodialysis. However, emergent hemodialysis sessions are financially covered by the national health system, so these patients are admitted to public hospitals as emergency cases and they undergo dialysis in the hopsitals' renal units. They are discharged after their dialysis session. In Greece, a different hospital is on duty to provide outpatient emergency service each day. Therefore, uninsured hemodialysis patients are treated in a different dialysis unit each time.

Our unpublished data show that these patients have a higher mortality rate (approaching 22% per dialysis year) than patients receiving regular hemodialysis in our unit. Possible reasons for this include inefficient dialysis dosing, a lack of standard monitoring and problems with follow-up after drug administration for the patients treated on an emergent basis. The uninsured population includes unemployed Greek-born patients, as well as immigrants and refugees from Southeastern Europe (e.g., Albania, Bulgaria and Romania), Asia (e.g., India and Pakistan) and Africa (e.g., Nigeria and Ivory Coast). Uninsured patients constitute a significant proportion of the total nephrology admissions to hospital (almost 19%), and their numbers are increasing dramatically each year. Action must be taken nationally and internationally so that uninsured immigrants and refugees with end-stage renal disease can receive adequate treatment and enjoy an acceptable quality of life in their new countries.

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Treatment of chronic respiratory diseases in obese people

Magali Poulain and colleagues do not appear to have considered the action of the renin–angiotensin system in their review of the effect of obesity on chronic respiratory diseases.[1] A recent study showed increased activation of the renin–angiotensin system in obese people.[2] However, a decrease in angiotensin-converting-enzyme activity may improve the efficiency of peripheral use of oxygen and respiratory muscle function in patients with chronic lung diseases.[3] Further, because several studies have shown that inhibition of the renin–angiotensin system may be a useful treatment for secondary erythrocytosis,[4–6] such an approach might also have profound benefits in the long-term treatment of erythrocytosis associated with obesity hypoventilation syndrome. Therefore, we suggest that therapy with angiotensin-converting-enzyme inhibitors or angiotensin II type 1 receptor blockers should be considered in the treatment of chronic respiratory diseases in obese people.

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DOI:10.1503/cmaj.1060122

Correction

In a recent article,[1] the subheading "The induction procedure for mild hyperthermia" should have read "The induction procedure for mild hypothermia." We regret the error.

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DOI:10.1503/cmaj.070353