This issue's letters

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Colorectal cancer screening

I commend Ryan Zarychanski and colleagues for highlighting the importance of colorectal cancer screening in their recent article.[1] I have a concern about their use of data from the 2003 Canadian Community Health Survey. Respondents to this survey were asked to recall their colorectal cancer screening history in the previous 10 years, and thus the survey most likely captured screening practices before 2001, the year when the first set of guidelines cited in the paper was published (Zarychanski and colleagues used recommendations released between 2001 and 2004 as reference standards to evaluate the adequacy of screening practices). It is not realistic to expect physicians to have incorporated the screening practices recommended in the guidelines into their clinical practice before the guidelines were published.

Zarychanski and colleagues imply that better screening can be achieved by increasing patients' contact with their family physician. Although I certainly agree that family physicians play a pivotal role in preventive health and early detection, I question the cost-effectiveness of encouraging patients to visit their family physician repeatedly to obtain appropriate screening. At a time when health care resources are scarce and family physicians are overworked, the low rate of participation in colorectal cancer screening would be better addressed by improving public awareness through education, by lobbying funding organizations for support to develop a national screening strategy and by recruiting additional family physicians to manage the anticipated challenges of population-based screening.

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Competing interests: None declared.

REFERENCE

1. Zarychanski R, Chen Y, Bernstein CN, et al. Frequency of colorectal cancer screening and the impact of family physicians on screening behaviour. *CMAJ* 2007;177:593-7.

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[Two of the authors respond:]

We thank Winson Cheung for his interest in our recent article.[1] Although we acknowledge that the recommendations of the Canadian Task Force on Preventive Health Care were published just 2 years before the survey was conducted, all 4 randomized controlled trials were published 8 years before the data were collected.[2–5] The fact is that colorectal cancer screening was underutilized in 2003. The responsibility for providing primary care physicians with direction on screening for various cancers mostly lies with the appropriate specialists. In this regard, Canada has lagged behind other nations in developing national guidelines on colorectal cancer screening and in instituting screening programs. In no way should family physicians be made scapegoats for the low rate of colorectal cancer screening.

Colorectal cancer screening will most likely be introduced to patients through their primary care physicians, as is the case with immunization programs. Our irrefutable finding that increased contact with family physicians was associated with increased screening rates led us to conclude that "contact with a family physician increases the odds of screening." However, this is not the only way to increase public participation in colorectal cancer screening; educational strategies and organized screening programs are also important mechanisms. Given that most patients will obtain their cancer screening information and advice from their family physician, the gastrointestinal specialty community (gastroenterologists, gastrointestinal surgeons and gastrointestinal oncologists) needs to do better at disseminating the relevant information to primary care providers and to the public.

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Competing interests: None declared.

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Staining method for kidney biopsy image

Ami Schattner and colleagues' description of a case of acute phosphate nephropathy[1] is of great interest and offers important information about the safest choice of bowel-cleansing preparations. I have a question about Figure 1: Was it not prepared using von Kossa stain rather than hematoxylin–eosin stain? The von Kossa staining method is not specific for calcium but is commonly used as though it were. The background renal parenchyma in the authors' image looks washed out, although the nuclei are more lilac than

expected with the standard counterstain. The calcium phosphate salts in Figure 1 are black and dark grey, whereas in undecalcified tissue sections stained with hematoxylin-eosin, the calcium is usually an intense basophilic blue-purple. When the von Kossa staining method is used, silver replaces the calcium (or another substance) and shows up as black or very dark burnt umber, as in the authors' image.

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Competing interests: None declared.

REFERENCE

1. Schattner A, Kopolovic J, Melzer E, et al. A 71-year-old woman with abdominal pain and acute renal failure. *CMAJ* 2007;177:454-5.

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[Two of the authors respond:]

We thank Henry Schneiderman for his comments on the stain we used to demonstrate the calcium deposits in the tubular lumina of our patient's kidney.[1] Schneiderman is right, of course, and we appreciate his meticulous and observant reading of our paper.

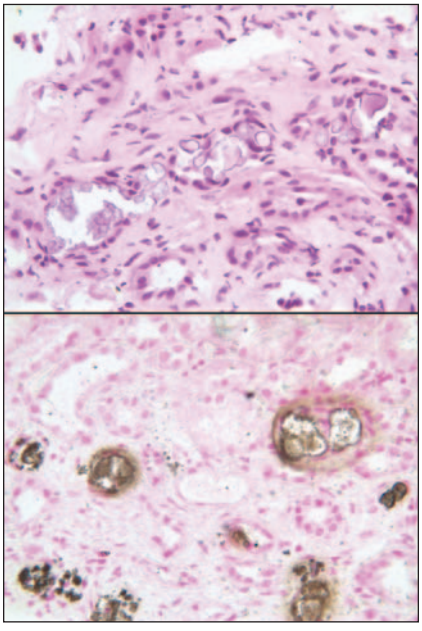

Figure 1: A kidney biopsy showing tubular atrophy and multiple calcium deposits (original magnification × 400) stained with hematoxylin–eosin stain (top) and von Kossa stain (bottom).

We made a special effort to use the von Kossa staining method for this kidney biopsy. This staining method is used as a histochemical method for calcium, but it is really a method for phosphate and carbonate. The calcium in the tissue section is replaced by silver; in the presence of phosphate and carbonate the silver is reduced to form crystals of silver phosphate and silver carbonate, which appear black and have a unique appearance in histologic sections. Figure 1 shows the 2 staining methods we used for our patient's kidney biopsy, which produced clearly different results. Hematoxylin–eosin staining was mentioned in our article by mistake; we apologize for this error.

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REFERENCE

1. Schattner A, Kopolovic J, Melzer E, et al. A 71-year-old woman with abdominal pain and acute renal failure. *CMAJ* 2007;177:454-5.

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Interprofessional collaboration

In a recent *CMAJ* news article, Wayne Kondro referred to a patient-centred collaborative care model adopted by delegates to the Canadian Medical Association's 140th General Council.[1] The model's focus on the physician as clinical leader does not capture the synergistic nature of collaborative practice.[2] Only through interprofessional communication and sharing of knowledge and skills can the provision of care be enhanced.[3]

In its position statement *Interprofessional Collaboration,* the Canadian Nurses Association stresses the importance of the health needs of individual clients and patients and of the population as determinants of care provision.[3] It states, "The right service is provided at the right time, in the right place and by the right care provider."

Mutual trust and respect are essential elements of interprofessional communication. If these elements are truly present, then members of the health care team can together determine, on the basis of their shared understanding of each other's roles and expertise, who will lead the team in a given patient care context.

Collaborative practice requires negotiation and a noncompetitive, nonhierarchical approach to patient and client care.[4] Until health care workers agree on what collaborative practice entails at all levels of the health care system, true interprofessional collaborative practice will not be observed and the benefits it offers will not be reaped.

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Competing interests: None declared.

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3. Canadian Nurses Association. Interprofessional collaboration [position statement]. Ottawa: The Association; 2006.
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DOI:10.1503/cmaj.1070156

Correction

A News brief in the November 20 issue about the election of Dr. William Fitzgerald as the 40th president of the Royal College of Physicians and Surgeons should have identified Dr. Fitzgerald as president-elect as of September 2007 and president as of September 2008.[1]

REFERENCE

1. Kondro W. News @ a glance. *CMAJ* 2007; 177:1346.

DOI:10.1503/cmaj.071790