

tasers.¹ Essentially every implication of the editorial was either erroneous or misleading. Only 4 of the 16 references were from the medical literature; most of the rest were newspaper articles.

The implication that TASER International asserts that a TASER electronic control device has never contributed to a death is erroneous. There are at least 6 cases of deaths from head injuries resulting from falls in which an electronic control device may have contributed to the fall, and TASER International warns of this risk in its training materials. Aside from these cases, we stand by TASER International's position that electronic control devices have never directly killed anyone.

The statement that TASER International has sponsored "just about all" of the research on electronic control devices is erroneous; 12 of the 17 published peer-reviewed human studies had no funding from TASER International. (They cannot be listed here because of the *CMAJ*'s space restrictions.)

The editorial stated that volunteers are almost never shocked in the chest or given sustained shocks. This was true in early studies but not in more recent studies.^{2,3}

The editorial also stated that members of the TASER International Scientific and Medical Advisory Board attempt to hide their associations with TASER International. This is untrue, as demonstrated by a letter published in the *Journal of the American College of Cardiology*.⁴

The statement (referencing a newspaper article) that TASER International has sued researchers for publishing their scientific results is untrue. The newspaper article was about James Ruggieri, who claimed, not in a peer-reviewed journal but in a bulletin of a small trade group of professional expert witnesses, that there would be a 50% fatality rate with use of a TASER electronic control device, on the basis of mysterious measurements and calculations. He also suggested that patients with cardiomyopathy should not comb their hair, remove their clothing or walk across carpeting because a static shock might induce fibrillation.

TASER International and the City of Akron, Ohio, did jointly go to court

under a state law that allows for independent judicial review of the opinions of medical examiners. This court case concerned an extreme situation in which the medical examiner consistently (in 3 cases) ruled that the use of an electronic control device constituted homicide, leading to criminal charges against several sheriff's deputies. After a 4-day legal proceeding in which numerous experts testified (including 3 forensic pathologists and 2 cardiac electrophysiologists), the judge ordered striking of the electronic control device as the cause of death and homicide as the manner of death.

The implication that TASER electronic control devices are a risk factor for deaths from excited delirium is erroneous. The editorialist gives no reference for this speculation nor can he, as excited delirium was recognized as a condition long before electronic control devices were invented.⁵⁻⁷ Even today, electronic control devices are involved in only a small minority of deaths from excited delirium.^{8,9}

The implication that a defibrillator should be used to treat excited delirium is incorrect. When death occurs with this disorder, with or without the involvement of an electronic control device, the presenting rhythm is characteristically asystole or pulseless electrical activity.⁹⁻¹¹ Defibrillation reverses fibrillation and therefore has no clinical indication in cases of excited delirium.

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Graham have served as consultants for TASER International. Mark Kroll has received travel assistance from TASER International for attending medical conferences. Hugh Calkins receives a nominal fee for serving on the Scientific and Medical advisory board of TASER International. Richard Luceri is a paid board member of TASER International and has received travel assistance for attending board meetings. William Heegaard has received travel assistance to attend a scientific medical advisory board meeting and has been paid for medical advice about conducted electrical devices.

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Hypertension in children and adolescents

We read with great interest the recent article by Karen Tu and colleagues concerning the prevalence of hypertension in adults aged 20 years and older.¹ The authors' estimate for 1995–2005 in Ontario was considerably higher than the recent estimate by Kearney and colleagues of a 24% relative increase in the prevalence of hypertension from

2000 to 2025 in developed countries.²

Din-Dzietham and colleagues recently reported a 37% relative increase in the prevalence of hypertension in American children and adolescents between 1988 and 1999.³ The upward trend was particularly evident in boys; Tu and colleagues reported a similar finding in adults.¹

Although the factors underlying the increase in the prevalence of hypertension are likely to be different in adults and children, obesity is an important determinant in both groups.^{4,5} In a recent analysis that combined data from the Third National Health and Nutrition Examination Survey (NHANES III, conducted from 1988 to 1994) and the NHANES 1999–2000 study, obesity accounted for nearly 30% of the increase in systolic blood pressure observed in children and adolescents over a 12-year period.⁵ Considering the potential impact that uncontrolled hypertension and high body mass index in children could have on the epidemiol-

ogy of hypertension in the future, public health strategies to prevent hypertension and reduce overweight and obesity in children and adolescents are urgently required.

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Correction

In the print version of a recent scientific article,¹ the seventh sentence in the third paragraph of the Interpretation section on page 232 should have been supported by reference 33, as follows: "A similar phenomenon was seen in a study performed in Denmark, where the incidence of diabetes was higher in a recent cohort (delivery during 1987–1996) than in an earlier one (delivery during 1978–1985).³³" The online version is correct.

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