

Letters

- Study conclusions should reflect results
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Study conclusions should reflect results

In their recent meta-analysis of the use of respiratory fluoroquinolones to treat community-acquired pneumonia, Vardakas and colleagues identified all-cause mortality in the intention-to-treat population as their primary outcome measure, but their main conclusion was that fluoroquinolone antibiotics were associated with higher treatment success than comparator antibiotics for severe forms of community-acquired pneumonia (treatment success was a secondary outcome).¹ The correct conclusion from their data should be that fluoroquinolones are no better than comparator antibiotics in the treatment of community-acquired pneumonia. A secondary conclusion should be that, in blinded and high-quality studies, there is no difference in mortality rate or treatment success for patients who receive fluoroquinolones versus comparator antibiotics. Moreover, it is unclear why the authors chose to include low-quality trials in their meta-analysis and to base their conclusions on such low-quality studies: this runs counter to common sense.

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Competing interests: None declared.

REFERENCE

1. Vardakas KZ, Siempos II, Grammatikos A, et al. Respiratory fluoroquinolones for the treatment of community-acquired pneumonia: a meta-analysis of randomized controlled trials. *CMAJ* 2008;179:1269-77.

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Three of the authors respond:

We thank Andrew Morris for his interest in our meta-analysis.¹ We chose mortality as our primary outcome because of the considerable mortality rate attributed to community-acquired pneumonia in several previous studies. However, the mortality rate for patients with pneumonia in several of the randomized controlled trials included in our meta-analysis was extremely low, and the mortality rate for patients in the subgroups with severe or bacteremic pneumonia was not reported. Therefore, we believe that the available data were too limited to reach a strong conclusion on this important outcome.

On the other hand, secondary outcomes such as treatment success may provide significant evidence regarding the effectiveness of antibiotic regimens. We stated in our article that macrolides and β -lactams (the comparators of fluoroquinolones in the randomized controlled trials included in the meta-analysis) are also effective for the treatment of community-acquired pneumonia. However, we believe that more data on the comparative effectiveness of various antibiotics are needed for patients with severe community-acquired pneumonia. Unfortunately, the available relevant blinded and high-quality randomized controlled trials enrolled only patients with mild or moderately severe pneumonia, a group in which the anticipated success rate would be higher for all antibiotics (compared with that in patients with severe community-acquired pneumonia). Thus, we elected to include all randomized controlled trials in our meta-analysis, an approach that is not unique in the literature; for example, the Cochrane Collaboration suggests including all the available evidence in the primary analysis and proceeding to sensitivity or subgroup analyses to refine the outcomes.² Finally, we cannot overemphasize that physicians should also be aware of the problems related to the use of the various antimicrobial agents, including fluoroquinolones: they may be associated with adverse

events such as arrhythmias,³ *Clostridium difficile*-associated diarrhea^{4,5} and the emergence of antimicrobial resistance.^{6,7}

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Competing interests: None declared.

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1. Vardakas KZ, Siempos II, Grammatikos A, et al. Respiratory fluoroquinolones for the treatment of community-acquired pneumonia: a meta-analysis of randomized controlled trials. *CMAJ* 2008;179:1269-77.
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3. Falagas ME, Rafailidis PI, Rosmarakis ES. Arrhythmias associated with fluoroquinolone therapy. *Int J Antimicrob Agents* 2007;29:374-9.
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5. Kazakova SV, Ware K, Baughman B, et al. A hospital outbreak of diarrhea due to an emerging epidemic strain of *Clostridium difficile*. *Arch Intern Med* 2006;166:2518-24.
6. Kopterides P, Koletsi PK, Michalopoulos A, et al. Exposure to quinolones is associated with carbapenem resistance among colistin-susceptible *Acinetobacter baumannii* blood isolates. *Int J Antimicrob Agents* 2007;30:409-14.
7. Falagas ME, Rafailidis PI, Kofteridis D, et al. Risk factors of carbapenem-resistant *Klebsiella pneumoniae* infections: a matched case control study. *J Antimicrob Chemother* 2007;60:1124-30.

DOI:10.1503/cmaj.1080133

Factual error

Ann Silversides' article¹ about the accidental overdose death of Ryan Lucio in 2002 at The Children's Hospital of Eastern Ontario states "Some tragedies have become public, thanks to the US Food and Drug Administration (FDA) or a measure of investigative reporting. ... His (Ryan's) death became public because of an FDA inspection, the results of which were posted on the agency's website."

This statement is not based on facts. While the FDA inspection took

place in early 2003, our error was reported to Canadian and American federal agencies on the day it was detected and to the public the day after.²

Ryan's death was a devastating event for the Lucio family. It rocked our hospital as well, leading not only to an extensive systematic review and a revamping of our procedures in clinical trials but also to considerable anguish and soul searching. To compound this tragedy by suggesting there was a cover up is simply incorrect and questionable reporting.

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Chief of the Medical Staff, The Children's Hospital of Eastern Ontario, Ottawa, Ont.

Competing interests: None declared.

REFERENCE

1. Silversides A. Clinical trials: chasing recruits. *CMAJ* 2009;180:375.
2. Agrell S. Child dies at CHEO after accidental overdose: Hospital miscalculated dosage of experimental drug. *Ottawa Citizen* 2002 Oct. 8.

DOI:10.1503/cmaj.1090011

Editor's note:

The *CMAJ* regrets this error and apologizes for any inconvenience that it may have caused.

Barbara Sibbald BJ

Deputy Editor, News and Humanities, *CMAJ*, Ottawa, Ont.

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Corrections

In a recent News article,¹ we quoted John Bridle as an asbestos expert but were not aware that he had received a conditional discharge on 2 counts of making false claims under the United Kingdom Trade Descriptions Act (1968) in relation to his business qualifications

and was fined £4000 (Can\$7116).² He was also found to have inaccurately claimed to be a consultant with the Vale of Glamorgan Trading Standards Department.³

REFERENCE

1. Collier R. Health advocates assail Canada's asbestos stance. *CMAJ* 2008;179:1257.
2. British Occupational Hygiene Society. *Asbestos surveyor found guilty of breaching Trade Descriptions Act*. Derby (UK): The Society; 2005. Available: www.bohs.org/newsArticle.aspx?newsItem=14 (accessed 2009 Feb. 27).
3. Office of Communications. Complaint by Professor John Bridle brought on his behalf by Fisher Scogins LLP. *Ofcom Broadcast Bulletin* 111:45-63.

DOI:10.1503/cmaj.090384

In the recent article by Boyd and colleagues,¹ the underlined sentence was omitted from the second paragraph of the Interpretation. This paragraph should have read as follows:

Trauma was also a significant contributing factor in a substantial proportion of asphyxia deaths. We found that 13% (12/92) of asphyxia victims who underwent autopsy had major trauma, defined as an injury severity score greater than 15.¹⁶ If the entire population of 204 fatalities is considered, this results in 10% (20/204) of cases with combined trauma and asphyxia, over and above the 24% (48/204) of cases determined to be caused by trauma alone. Thus, in western Canada, during the study period, major trauma contributed to a total of 33% (68/204) of avalanche deaths overall and,

for ice climbers, to more than 50% (7/13) of deaths. This is a far greater proportion than reported in a well-designed Austrian study, in which trauma was reported as the cause of death in only 5.6% of cases.⁹ In our study, trees were identified as the most common objects hit in trauma deaths. This may be explained by the much greater access to forested ski terrain in Canada²⁰ than in Europe. In a recent study from Utah, United States, trauma was the immediate cause of death in 5.4% of cases and contributed to death in an additional 8.9% of 56 avalanche fatalities.²¹ Variations between studies point to differences in geography, such as mountain topography and distances for rescue flights, as well as demographics, notably different activity types.^{9,21-23}

REFERENCE

1. Boyd J, Haegeli P, Abu-Laban RB, et al. Patterns of death among avalanche fatalities: a 21-year review. *CMAJ* 2009;180:507-12.

DOI:10.1503/cmaj.090385

In a recent Teaching Cases article about loss of vision in a patient with neurofibromatosis,¹ the caption for Figure 5 should have identified the 2 magnetic resonance images as T1-weighted images.

REFERENCE

1. Mumoli N, Cei M, Bartolomei C, et al. A patient with loss of vision in the right eye and neurofibromatosis type 1. *CMAJ* 2009;180:203-6.

DOI:10.1503/cmaj.090411

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