they are certainly going to be hard-pressed shoppers. I would submit that until industry really get serious about stopping the almost universal harmful addition of excess sodium to commercial foodstuffs (or the government actually does something), excellent articles like Dr. Mohan's will amount to little more than wishful thinking.

**Malcolm Brigden MD**
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**For the full letter, go to:** www.cmaj.ca/cgi/eletters/181/9/605#235107

DOI:10.1503/cmaj.110-2006

## Diagnosis of asthma

A significant weakness of the excellent work by Kaplan and colleagues[1] relates to a lack of discussion on the spirometric overlap between asthma and chronic obstructive pulmonary disease (COPD) and how this may lead to disease misclassification. This clarification is important since their diagnostic algorithm for asthma, Figure 1, contains a decision node labelled "Spirometry results consistent with asthma" referring to improvements in forced expiratory volume in one second (FEV1) after bronchodilator challenge; changes that can also be seen in many patients with COPD[2]. It is also important to provide clarification about what is meant by "reversibility of airflow obstruction" as this applies to asthma and COPD.

It could be argued that airflow obstruction defined by a reduction in the ratio of FEV1 and forced vital capacity (FVC) is irreversible in COPD since, by definition, it must remain below some predetermined value after bronchodilator challenge. However, a persistent reduction in FEV1/FVC after bronchodilation in COPD may be associated with significant changes in airway calibre (FEV1) similar to that recommended for the spirometric diagnosis of asthma. Furthermore, the FEV1/FVC may remain reduced after bronchodilator challenge in asthma; highlighting the spirometric overlap that may exist between asthma and COPD in terms of FEV1 and FEV1/FVC changes after bronchodilator challenge. Therefore, COPD can be characterized by a persistent reduction in FEV1/FVC after bronchodilation irrespective of airway calibre changes.

For spirometric diagnoses of asthma, criteria for changes in airway calibre must be met irrespective of the FEV1/FVC value; the latter is often normal in asthmatics. This information is not clearly apparent in the diagnostic algorithm for asthma, Figure 1, and could result in disease misclassification in some patients.

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2. Tashkin DP, Celli B, Senn S, et al. A 4-year trial of Tiotropium in Chronic Obstructive Pulmonary Disease. *N Engl J Med* 2008;359:1543-54.

**For the full letter, go to:** www.cmaj.ca/cgi/eletters/181/10/E210#243521

DOI:10.1503/cmaj.110-2010

## Social pain and opioid use

The letter by Susan Rosenthal[1] indicates, likely by intention, a simplification tying opioid use to social pain. To me, increasing opioid use has more to do with physicians finally learning that unmitigated pain, especially chronic pain, is no longer acceptable. My own reality is that chronic use with judicious controls (e.g., better acceptance recently for giving methadone for chronic pain) can often allow some reasonable function. As GPs, we are often truly the first to triage for chronic pain patients, but also the option of last resort required to keep prescribing with frustrating "triplicate/duplicate" security-laden prescription pads, periodic urine screening and so on. Being asked to take on police-type thinking on top of all this can be a challenge, very different from the therapeutic impulse that underlies our work ethic.

**John de Couto MD**
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**For the full letter, go to:** www.cmaj.ca/cgi/eletters/181/11/827-a#249094

DOI:10.1503/cmaj.110-2000

## CIHR and Prigent

The debate over the appointment of a seasoned scientist with private-sector experience to the governing council of the Canadian Institutes of Health Research[1] (CIHR) is based on innuendo rather than fact. CIHR should be commended for appointing Dr. Bernard Prigent. He brings strong international credentials in pharmaceutical research and development and has been recognized by his peers in the scientific and academic community for championing principled partnerships between industry, academia and governments aimed at improving Canada's performance in health research. Furthermore, the governing council does not make decisions with respect to which researchers/projects will be funded, as this is the responsibility of the scientific council, based on the advice of peer review panels. Dr. Prigent's appointment is consistent with CIHR's mission, which is "the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system."

**Russell Williams, president**
Canada's Research-Based Pharmaceutical Companies (Rx&D)
**Yves Morin, cardiologist and chair**
Rx&D Health Research Foundation
Ottawa, Ont.

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