Cholesterol microembolization syndrome

The title of this paper is inaccurate and misleading because we cannot be certain that the patient had cholesterol embolism. Definitive diagnosis requires a positive biopsy. The circumstantial evidence for cholesterol embolism is tenuous in this case. A computed tomography (CT) scan showed small plaques in the patient’s aortic wall, but this finding is virtually ubiquitous in elderly men. Moreover, a similar study the previous year, when he had already been on warfarin for six months, was normal. Clinically significant cholesterol embolism generally arises from large ulcerated plaques. Leucocytoclastic vasculitis has been associated with warfarin therapy. We are told that vasculitis was excluded, but this statement is unjustified because vasculitis in this context can be excluded only by a negative biopsy of a skin lesion. I do not see the logic in the authors’ statement that recurrence of the skin lesions with the logic in the authors’ statement that recurrence of the skin lesions with the use of phenindione confirmed the diagnosis of cholesterol microembolization syndrome. An accurate title of this paper would be: Purple toe syndrome: a complication of anticoagulant therapy.

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REFERENCE

For the full letter, go to: www.cmaj.ca/cgi/letters/182/9/931#55990

The authors respond:

We thank Dr. Kay for his remarks about our article. Histologic confirmation of cholesterol microemboli was missing in our case and we agree that a biopsy, if allowed, should have been performed.

Small atherosclerotic findings are ubiquitous in elderly men, but in our case, these lesions were hallmarks of general atherosclerotic arterial disease and hence susceptibility to cholesterol microembolization syndrome.

Medical history, clinical status and laboratory findings did not support the hypothesis of leucocytoclastic vasculitis as the cause of our patient’s ‘purple toes’. Although vasculitis is known to rarely occur with the use of warfarin, it has not been documented to be due to the use of phenindione. Thus, leucocytoclastic vasculitis seems unlikely as an explanation for our patient’s symptoms.

We admit that Dr. Kay’s suggestion for the title of our case report is well argued and is perhaps even more accurate. By using the present title we aimed to alert physicians about the possibility of cholesterol microembolization syndrome in warfarin treated patients, because the number of patients on warfarin is large and increases continuously.

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For the full letter, go to: www.cmaj.ca/cgi/letters/182/9/931#595648

Energy drinks: beverage industry response

The Canadian nonalcoholic beverage sector wants to set the record straight about several factual errors in the editorial “‘Caffeinating’ children and youth.”

We strongly agree that energy drinks should be marketed responsibly. However, it is important to understand the Canadian regulatory context for these products, which is already the most stringent in the world.

In Canada, energy drinks are formulated, labelled and marketed in accordance with Health Canada’s Natural Health Product Regulation and policies. They are not regulated or labelled as foods, as suggested in the editorial. Energy drinks must be marketed in compliance with the Consumer Advertising Guidelines for Marketed Health Products.

Energy drinks are intended for adults; the labels clearly indicate that this category of beverage is not recommended for children and people who are sensitive to caffeine, and they...