

Cholesterol microembolization syndrome

The title of this paper¹ 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 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

1. Varis J, Kuusnieemi K, Järveläinen H. Cholesterol microembolization syndrome: a complication of anticoagulant therapy. *CMAJ* 2010;182:931-3.

For the full letter, go to: www.cmaj.ca/cgi/eletters/182/9/931#555990

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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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Getting them off the battlefield

I read, with interest and compassion, the article lamenting some of the horrible urogenital (and other) injuries sustained by military personnel in Iraq and Afghanistan.¹ What's missing is any mention of the thousands of civilians injured in the conflict and how often military personnel attempt to help them (or not, and why not). What might become of the whole campaign if more military physicians took the Hippocratic position of "primum non

nocere" hinted at by the executive from the American Urology Association who stated that urologists are saying, "I'm not seeing a way of helping these patients short of getting them off the battlefield."¹ Imagine doing so, prophylactically, for all the people deemed in danger of such injuries. Why not? Imagine ...

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Competing interests: Vietnam War resister; former US Navy reserve clinical clerk; board member, Physicians for Global Survival.

REFERENCE

1. Woodward C, Eggertson L. Homemade bombs and heavy urogenital injuries create new medical challenges. *CMAJ* 2010;182:1159-60.

For the full letter, go to: www.cmaj.ca/cgi/eletters/182/11/1159#595764

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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."¹

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.²

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