Cholesterol microembolization syndrome

The title of this paper[1] 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.

J. Michael Kay MD
Department of Pathology and Molecular Medicine, McMaster University, Hamilton, Ont.

REFERENCE

1. Varis J, Kuusnieeemi 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

DOI:10.1503/cmaj.110-2114

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/eletters/182/9/931#595648

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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 …

Paul J. Eisenbarth MD
Hanover, Ont.

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

DOI:10.1503/cmaj.110-2111

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

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include warnings not to mix the beverage with alcohol. Unlike coffee and iced coffee beverages, which have no warnings or quantitative labelling, all energy drinks declare levels of caffeine from all sources (natural and synthetic).

In Canada, mainstream energy drinks contain less caffeine by volume than a cup of filter drip coffee (80–140 mg per energy drink v. 179 mg per 237 mL cup of coffee). Labels on energy drinks advise consumers to have only one drink per day. Nowhere in this country are there energy drinks with caffeine levels approaching those suggested in the editorial.

We do agree that education on the proper consumption of this unique product category is important — which is why the industry has offered to partner with Health Canada on a consumer education campaign. The campaign needs to sensitize all Canadians to the sources of caffeine in their diets and to Health Canada's recommended intake levels of 400 mg/d per person and 2.5 mg/kg of body weight for children under the age of 12.

Energy drinks have been the subject of extensive review and analysis by regulatory authorities worldwide. Without exception, these reviews have confirmed the safety of these products in markets around the world.

Justin Sherwood
President, Refreshments Canada,
Toronto, Ont.

Competing interests: Justin Sherwood represents the nonalcoholic beverage sector.

REFERENCES

1. MacDonald N, Stanbrook M, Hébert PC. "Caffeinating" children and youth. *CMAJ* 2010;182:1597.
2. *Issuance of the final consumer advertising guidelines for marketed health products (for nonprescription drugs including natural health products).* Ottawa (ON): Health Canada. Available www.hc-sc.gc.ca/dhp-mps/advert-publicit/pol/guide-ldir_consom_consum-eng.php (accessed 2010 Sept. 9).

For the full letter, go to: www.cmaj.ca/cgi/eletters/cmaj.100953v2#594265

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Bravo and beware

Bravo for your Aug. 30 editorial, "Governments, pay for smoking cessation."[1] The only potential loser would be the tobacco industry, of whose influence we should be wary.

Clinical tobacco intervention is one of the top three preventive measures,[2] and although, stop-smoking medication is one of the most effective, only Quebec has made it widely available to its citizens (since October, 2000).

Cigarette-smoking is not an equal-opportunity addiction. Two of its major determinants, genetics and years of education, are not evenly distributed across the population.

Furthermore, the short-term gain in terms of hospital and surgical complications avoided by stopping smoking is spectacular. Failure to invest in not only medication but also in paying for the systematic delivery of clinical tobacco interventon amounts to fiscal and administrative malpractice.

But one editorial in the *CMAJ* won't be enough. The resistance to doing the obvious is deeply entrenched.

Frederic Bass
Vancouver, BC

Competing interests: Member, Varenicline Advisory Committee, Pfizer

REFERENCES

1. Penz ED, Manns BJ, Hébert PC, et al. Governments, pay for smoking cessation. *CMAJ* 2010 Aug 30. [Epub ahead of print]
2. Maciosek MV, Coffield AM, Edwards NM, et al. Priorities among effective clinical preventive services: results of a systematic review and analysis. *Am J Prev Med* 2006;31:52–61.

For the full letter, go to: www.cmaj.ca/cgi/eletters/cmaj.101140v1#595875

DOI:10.1503/cmaj.110-2117

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