Evidence-based sustainability

I was surprised to read the editorial by Hébert and colleagues, which implied that Canada's health care system is financially sustainable when the evidence clearly shows that it is not.[1] From 2000–2009, the federal government's revenue increased 22%,[2,3] and Ontario's revenue increased 49%.[4,5] Meanwhile, Ontario's health care costs increased by an unsustainable 88%.[4,5]

With rapidly expanding expensive investigative tools, treatments and medications in conjunction with a free, comprehensive, universal health care system, both patients and physicians are being persuaded to perceive of "limitless essential services." Unfortunately, we do not have "limitless funds." There is no Canadian politician or leading physician who is prepared to state clearly that health services must be limited to those that are justified and tort reform must be introduced. Any provincial health costs that exceed perhaps 35% of provincial program spending should be raised from premiums and a portion of health care expenses based on a patient's ability to pay. Very fair, very Canadian.

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Oral contraceptives and risk of gallbladder disease

Etminan and colleagues reported on an interesting study in which they found merely a little association between the use of oral contraceptives and gallbladder disease.[1] This resembled the results of our recently completed observational study (unpublished data: 2011) in which the cumulative adjusted rate ratio (RR) was 1.01 (95% confidence interval [CI] 0.97–1.12).

However, we found that oral contraceptives are an important contributor to gallbladder disease in patients with a body mass index (BMI) over 30 during drug administration (RR 1.46, 95% CI 1.20–1.79). Etminan and colleagues gave information about the history of obesity but not the weight or BMI of the participants. They also did not perform subgroup analysis on the relationship between a history of obesity and gallbladder disease. Given large differences in diet and somatotypes in Occidental and Asian women, we think their study should have included a subgroup analysis based on demographic characteristics specifically for BMI or weight. Although we concluded from our study that women with a BMI less than 30 should not be concerned about gallbladder problems when taking oral contraceptives, those with a BMI over 30 should be careful.

We want to know whether Etminan and colleagues' retrospective study could obtain the same results as ours.

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We agree with Wang and colleagues that the risk of gallbladder disease with the use of oral contraceptives may be modified by different levels of BMI.[1] Unfortunately, information on BMI was not available for our study.[2] We agree that future research should examine this issue carefully.

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***CMAJ* 2011. DOI:10.1503/cmaj.110-2066**

Absolute risk reduction a must

After reading the article by Wells and colleagues on cardiac resynchronization therapy,[1] I was not sure that the article had come from *CMAJ*; it sounded like a salesperson had just dropped by and "detailed" me on the merits of putting a pacemaker/implantable cardioverter defibrillator into every patient with NYHA (New York Heart Association) class II disease.

To quote the authors, there was "no need for further clinical trials" because "the cumulative evidence is now conclusive" that there is "an unequivocal benefit … in reducing all-cause mortality." Nowhere in the article is the absolute risk reduction mentioned. One would have to refer to Figures 2 and 3 to calculate it.

What happened to the peer review process at *CMAJ*? And where was the *CMAJ* editor? How can an article be published without the most relevant information in a trial — the absolute risk reduction?

I thought this was just an oversight, and I proceeded to the next excellent article in that issue by Eisenberg and associates.[2] Again, no absolute risk reduction! How can I counsel patients

on the hazards of cardiac imaging without this crucial information?

I humbly request that *CMAJ* include absolute risk reduction and/or increase in every research article published.

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1. Wells G, Parkash R, Healey JS, et al. Cardiac resynchronization therapy: a meta-analysis of randomized controlled trials. *CMAJ* 2011;183:421-9.
2. Eisenberg MJ, Afilalo J, Lawler PR, et al. Cancer risk related to low-dose ionizing radiation from cardiac imaging in patients after acute myocardial infarction. *CMAJ* 2011;183:430-6.

***CMAJ* 2011. DOI:10.1503/cmaj.110-2067**

Editor's response

CMAJ is grateful for the reminder that what matters to a patient is the absolute risk.[1] We should have made this easier for readers to find, especially in the second article to which Shaw refers.

The total mortality on optimal medical therapy was easy to see in Wells and colleagues' article;[2] in Figure 2 it was 250/1013, or 24.5%. The absolute risk of cancer was less easy to find in Eisenberg and associates' article.[3] One estimate might be 12 020 cancers diagnosed in 82 861 patients, as reported in the abstract; these occurred over an average follow-up time of five years according to the results, which suggests about 2.9 cases per 100 person years.

What these summary absolute risks hide, however, is that they may not be appropriate for an individual patient. Risk may vary with characteristics such as age, sex, severity of illness, comorbidity and family history. There is a long tradition of debate about whether to present research findings in terms of relative measures, which tend to be more stable between patient populations, or absolute measures, which have more immediate interpretability for clinicians and patients.[4,5] We prefer to have both where possible, and we will make renewed efforts to remind authors to provide them.

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***CMAJ* 2011. DOI:10.1503/cmaj.110-2068**

Some letters have been abbreviated for print. See www.cmaj.ca for full versions.

Correction

Folate status of the population in the Canadian Health Measures Survey

In the February 8, 2011 issue of *CMAJ*, two errors occurred in the article by Colapinto and colleagues.[1] The revised statements are below, with the correction in italics:

"Samples were thawed, diluted (1-in-26) with 0.5% ascorbic acid solution, allowed to incubate at room temperature *for 18 minutes* and then analyzed for folate using …" (Methods section).

"Given the absence of folate deficiency in the general population and the apparent shift toward Canadians having high *red blood cell* folate concentrations …" (Interpretation section).

CMAJ regrets the errors.

Reference

1. Colapinto CK, O'Connor DL, Tremblay MS. Folate status of the population in the Canadian Health Measures Survey. *CMAJ* 2011;183:E100-6.

***CMAJ* 2011. DOI:10.1503/cmaj.110-2069**