Binge drinking

The risky use of alcohol is greatly underappreciated by society as a substantial source of harm to health and safety. A few points of clarification are required for the editorial by Flegel and colleagues.[1]

The rates of binge drinking reported by the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) should be seen as conservative, given that surveys of this type underestimate alcohol sales by 60% to 70%.[2] When we compare what people tell us they drink with what is sold, we find that self-reported drinking accounts for only 30% to 40% of official sales.[3]

In 2007, an expert working group released recommendations for a national alcohol strategy, which is the first national strategy developed for alcohol in Canada.[4] Many of the report's 41 recommendations relate to the problem of binge drinking.

The National Alcohol Strategy Advisory Committee has since been working to implement several of the recommendations in the National Alcohol Strategy, including developing a national consensus on low-risk drinking guidelines and building capacity for alcohol screening and brief interventions in primary care. More information is available from the Canadian Centre on Substance Abuse (CCSA) (613 235-4048).

Although I agree that more research is needed to identify effective approaches to reduce the rates of binge drinking, there is already very good evidence for some interventions, including screening and brief interventions. The crucial need is to find creative ways to roll out these proven interventions at the scale needed to affect consumption patterns at the population level.

The economic burden of alcohol to Canadian society was estimated to be $14.6 billion in 2002, with direct costs accounting for $7.5 billion. A report soon to be published by CCSA shows that in most provincial and territorial jurisdictions, direct costs exceeded direct revenue from the sale of alcohol for fiscal year 2002–03.[5]

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Canadian Centre on Substance Abuse, Summerland, BC

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3. Stockwell T, Zhao J, Thomas G. Should alcohol policies aim to reduce total alcohol consumption? New analysis of Canadian drinking patterns. *Addict Res Theory* 2009;17:135-51.
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I believe there is an error in the editorial by Flegel and colleagues.[1] The editorial states: "Over the past five years, 8.8% of Canadians reported binge drinking [i.e., five or more per sitting for men, four or more for women]," citing CADUMS.[2] I am very familiar with those data. According to the data, 19.2% of Canadians 15 years of age or older reported that they consumed four or more (women) or five or more (men) alcoholic drinks at least monthly over the past year; 7% reported doing so at least weekly over the past year.

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2. Canada Health and Drug Use Monitoring Survey. Ottawa (ON): Health Canada. Available: www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2009/tables-tableaux-eng.php#t6. (accessed 2011 Jan. 6).

***CMAJ* 2011. DOI:10.1503/cmaj.111-2017**

Editor's response

Dr. Davis is not clear about where his cited rates are from. The citation for the 8.8% rate in the editorial is correct, according to Table 1 of the 2009 CADUMS report.[1] It derives from adding the percentage estimates in column 3 (the last two rows). The table we used was selected because we wanted to represent the prevalence of people who engage in binge drinking on a regular basis of some frequency.

If the suggestion is that the rates are rather higher, then our comments are so much the more compelling.

Kenneth M. Flegel MDCM MSc
Senior Associate Editor, *CMAJ*

Reference

1. Canada Health and Drug Use Monitoring Survey. Ottawa (ON): Health Canada. Available: www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2009/tables-tableaux-eng.php#t6. (accessed 2011 Jan. 6).

***CMAJ* 2011. DOI:10.1503/cmaj.111-2018**

Restaurant industry opposes calorie content disclosure

I was disappointed to read that the Canadian Restaurant and Foodservice Association (CRFA) remains opposed to menu labelling.[1] Since 2009, Ontario's doctors have been calling on chain restaurants and school boards across the province to post calorie counts on menus and menu boards, and we continue to stand by that call. Although the CRFA is resistant to this important initiative, its US counterpart, the National Restaurant Association, has said, "The passage of this provision [menu labelling] is a win for consumers and restaurateurs, [and] we know the importance of providing consumers with the information they want and need."[2]

The Ontario Medical Association (OMA) report, *Treatment of Childhood Overweight and Obesity*, shows that 25% of children are overweight or obese, and 75% of obese children become obese adults.[3] Overall, the impact of overweight and obesity on health is estimated to cost Ontario $2.2 to $2.5 billion per year. Ontario's doctors believe that menu labelling will have an impact on obesity rates, but it is not the only initiative that is needed to tackle the obesity epidemic. The OMA also wants to see an education campaign that teaches people

about the importance of calories in healthy weight management.

Physicians have seen first-hand the shock from patients when they find out that something like a tuna melt can have twice as many calories as a double cheeseburger. By learning more about calories and their impact on overall health, and by having better information about the food on menus, consumers will be empowered to make better and informed choices.

Mark MacLeod MD
President, Ontario Medical Association, Toronto, Ont.

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***CMAJ* 2011. DOI:10.1503/cmaj.111-2013**

Efficacy and practicality of codeine

Thank you for bringing this important issue to the attention of *CMAJ*'s readership.[1] As clinicians, we all wish to deliver evidence-based and effective pain treatment to our patients by considering efficacy, safety and practicality. The editorial focused on safety; we'd like to highlight the limitations of codeine in the other areas.

Clinical trials have demonstrated repeatedly that codeine is no more effective than ibuprofen in providing relief of mild to moderate pain.[2–4] In many trials, the number of side effects reported by patients receiving codeine was substantially higher than those reported by patients receiving ibuprofen.[2–4] These adverse effects, reported by 50% to 71% of the patients, likely affect compliance. In addition, the poor palatability of codeine suspension is an issue in children, who rated this aspect of their experience with codeine as highly unsatisfactory.[3]

Given the well-recognized negative side-effect profile for codeine, can we justify choosing a drug that will likely be avoided by the patient in clinical scenarios where ibuprofen has a comparable clinical effect with a more favourable profile?

We cannot ignore the real safety concern associated with genetic differences in metabolism of codeine for a subsection of the population. However, clinical trials also suggest that codeine is no more effective than ibuprofen, and there are several drawbacks that likely affect compliance and effectiveness. Because there are alternative analgesics (e.g., ibuprofen) and opioids (e.g., hydrocodone and oxycodone) available with efficacy and safety profiles superior to that of codeine, we advocate for their thoughtful/judicious use over codeine.

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Samina Ali MDCM
Associate professor, University of Alberta, Edmonton, Alta.

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***CMAJ* 2011. DOI:10.1503/cmaj.111-2012**

Dose of vitamin K in emergency reversal of warfarin anticoagulation

Lin and Callum recommend 10 mg of vitamin K to reverse warfarin anticoagulation in emergencies.[1] However, a dose this high may not be required for all "emergent" situations. It is important to differentiate between emergencies on the basis of severity of bleeding and urgency of reversal of warfarin anticoagulation. Anticoagulation can be reversed with 2.5 to 5 mg of vitamin K administered intravenously in a patient taking warfarin who requires urgent surgery.[2] This lower dose of vitamin K is especially important when anticoagulation needs to be resumed once hemostatis has been achieved after surgery.

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Section of hematology/oncology, Department of Internal Medicine, University of Manitoba, Winnipeg, Man.

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***CMAJ* 2011. DOI:10.1503/cmaj.111-2011**

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

CORRECTIONS

Shortness of breath while sitting up

In the Jan. 11 issue of *CMAJ*,[1] the name of the corresponding author was incorrect. It should have been Dr. Shih-Tsung Cheng, zovirax kimo@yahoo.com.tw. *CMAJ* regrets any inconvenience this error may have caused.

Reference

1. Lee C-H, Cheng S-T. Shortness of breath while sitting up: hepatopulmonary syndrome. *CMAJ* 2011;183(1):80.

***CMAJ* 2011. DOI:10.1503/cmaj.111-2016**

Congenital varicella syndrome

In the Feb. 8 issue of *CMAJ*,[1] the name and degree for the second author were incorrect; the entry should have read: Panagis Moschopoulos PhD. *CMAJ* regrets the error.

Reference

1. Cohen A, Moschopoulos P, Stiehm RE, et al. Congenital varicella syndrome: the evidence for secondary prevention with varicella-zoster immune globulin. *CMAJ* 2011;183(2):204-8.

***CMAJ* 2011. DOI:10.1503/cmaj.111-2019**