FOR THE RECORD

Red pencil retreat

After a decade in various capacities at *CMAJ*, including a stint as interim editor-in-chief, Dr. Noni MacDonald is setting aside her red pencil.

"It's been an incredible run," says MacDonald, who reports that her husband is delighted she won't constantly be on the phone, even while on vacation, dealing with journal business.

"I've been with the journal now for 10 years," adds the professor of pediatrics and computer science at Dalhousie University in Halifax, Nova Scotia. "It's been hard work in many instances but also a great opportunity to help a real quality journal grow. It's time for me to step down and I'm simply delighted that Editor-in-Chief Dr. John Fletcher is planning to use the resources made available by my departure to hire a fellow."

MacDonald holds a cross appointment with the pediatric infectious diseases group at the IWK Health Centre in Halifax and while with Dalhousie, was the first woman to have been a dean of medicine at a Canadian medical school. Prior to joining Dalhousie, MacDonald, who obtained her medical degree from the University of Ottawa in Ontario, spent 18 years at the Children's Hospital of Eastern Ontario and Ottawa General Hospital, while establishing such programs as one to provide pediatric palliative care. MacDonald is also the founding Editor-in-Chief of *Paediatrics and Child Health*.

A founding member of the World Health Organization's Global Advisory Committee on Vaccine Safety, MacDonald's international ventures have also included the establishment of MicroResearch, which provides infrastructure and grant support for researchers in Africa, particularly in the area of maternal child health. Her many laurels include being an elected fellow of the Society for Pediatric Research, the Canadian Society for Clinical Investigation, the Infectious Diseases Society of America, the Canadian Institute of Academic Medicine and a founding Fellow of the Canadian Academy of Health Sciences.

MacDonald expects to turn her attention in the future to even more international initiatives. "I have many calls on my time and I really do need to devote more of my time to a couple of projects that I'm working on internationally," she says.

MacDonald joined *CMAJ*'s Journal Oversight Committee in 2002 and became the interim editor-in-chief in 2006 before becoming the section editor for population and public health, as well as a member of the editorial writing team.

Fletcher says MacDonald's departure leaves many at *CMAJ* with a "heavy heart."

"Noni has been a strong supporter of the journal and has brought quality and stability in her time on the Journal Oversight Committee, as interim editor in chief and as an associate editor at the head of the public health section." — Wayne Kondro, *CMAJ*

Hooked on the Internet

Although Internet addiction is not yet formally recognized as a disorder, a team of researchers in the province of Quebec has developed guidelines for the diagnosis and treatment of people who are hooked on surfing the Web.

It's "an anticipatory response for future needs," says Louise Nadeau, professor of psychology at the University of Montreal and lead author of the guidelines, *La cyberdépendance: état des connaissances, manifestations et pistes d'intervention* (Available only in French at: www.centredollardcormier.qc.ca/cdc/documents/cybercomplet.pdf).

Produced by Le Centre Dollard-Cormier through a $75 000 grant provided by l'Agence de la santé et des services sociaux de Montréal, the guidelines sketch the symptoms of Internet addiction and generally recommend treatments similar to those used in treating people with a gambling problem. Traditionally such treatment has been based on some form of cognitive–behavioural therapy, although clinicians in some jurisdictions are experimenting with the use of content control software to limit the ability of people to visit websites.

According a literature review and a survey conducted by the Quebec team, signs of problematic Internet use can include a desire or repeated failure to control or cut use; agitation or irritability when trying to control or reduce use; negative impact on interpersonal, professional and/or other relationships as a consequence of use; continued use despite being aware use is problematic; and lying to family or therapist to conceal the extent of use.

Because Internet addiction is a relatively recent phenomenon, the authors of the guidelines say their review raised as many questions as answers and stressed that the resulting guidelines are based primarily on anecdotal evidence. They nevertheless contend that the guidelines should better equip physicians to handle the problem.

Nadeau also stresses that while people who are addicted to Web surfing may share clinical features with those addicted to alcohol, illicit drugs or gambling, clinicians should not pigeonhole the former into the same camp as the latter. "What we tried to convey in this text is that clinicians should listen clearly because obviously what these patients have to say and how their lives are probably have some similarities with things we already know with substance abuse and gambling, but there is a whole new clinical feature that we really need to listen to with ears that are open to hearing something different and something new."

Neither the *Diagnostic and Statisti-*

cal Manual of Mental Disorders IV published by the American Psychiatric Association nor the *ICD-10 Classification of Mental and Behavioural Disorders* published by the World Health Organization recognize Internet addiction as a mental disorder.

But developers of the guidelines say treatment centres in eight regions of Quebec, have encountered patients seeking help with curbing their Internet use. "Even if neither of the two world-wide classifications of mental disorders currently define Internet dependence, individuals who seek help from rehabilitation centres as a result of their problematic use of the Internet experience real suffering," Nadeau stated in a press release (Translation by author, www.newswire.ca/fr/story/921139/la-cyberdependance-etat-des-connaissances-manifestations-et-pistes-d-intervention). — Michael Monette, Ottawa, Ont.

Opportunity lost

Canadian governments are squandering an opportunity to reduce the toll taken by diet-related disease with their failure to compel calorie labelling on restaurant menus, according to the Centre for Science in the Public Interest.

Unlike the United States, where the government has passed a law that will mandate calorie disclosures at chain restaurants once the Food and Drug Administration finalizes regulations this year, Canadian governments have not acted on erstwhile promises to implement mandatory restaurant menu labelling as part of a bid to reduce obesity and the incidence of diet-related diseases such as diabetes and cardiovascular disease, the Centre states in a report, *Writing on the Wall: time to put nutrition information on restaurant menus* (http://cspinet.org/canada/pdf/writing-on-the-wall.complete-report.pdf).

"While federal and provincial governments have the authority to mandate nutrition information on restaurant menus, the national and international character of the food supply, Health Canada's considerable nutrition-science expertise, and the federal government's constitutional authority to enact menu labelling and other nutrition-related policies make it better suited to use its regulatory and spending levers to help curb nutrition-related diseases. Unfortunately, the federal government has failed to issue nutrition-improving regulations as if Canada had thousands of lives to spare every year, and as if governments presided over full treasuries and strong economic growth."

The report argues that voluntary approaches toward disclosure of the caloric content of restaurant foods have been an abysmal failure in other countries. "Plainly, consumers cannot exercise informed choice or identify lower-calorie or lower sodium options if information about the amounts of calories and sodium is not readily available at the point of purchase prior to purchase."

Only a regulatory approach will achieve the desired outcomes, it states, recommending that governments:

"1. Require chain restaurants to disclosure on menus and menu boards, next to each food item: a) the number of calories, and b) where applicable, symbols (such as red asterisks, **) flagging foods with high or very high levels of sodium; and mandate the placement of a brief explanation of the symbols at the bottom of the menu with a note stating: 'The average adult should consume about 2,000 calories per day and about 1,500 mg of sodium per day,' which research indicates could amplify the effects of nutrient disclosures.

2. Require that all chain restaurants provide free brochures that disclose all the nutrition information required on Nutrition Facts labels of prepackaged foods (especially saturated fat and trans fat).

3. Exempt small restaurant operations and short-term menu items. Menu labelling laws should apply only to chains that have, nationally, at least $10 million in annual sales or 10 outlets, whichever the chain is willing to provide proof of to qualify for the exemption. Smaller restaurant companies should be encouraged to voluntarily provide nutrition information. Menu items that are offered for sale fewer than 31 days of the year could be exempt.

4. Require chain restaurants (as well as manufacturers of prepackaged foods) that are required to provide nutrition information on menus, menu boards, or labels to provide and continuously update complete nutrition and ingredient information to a publicly accessible government database. That would facilitate restaurants' constructive participation in the *Sodium Reduction Strategy for Canada* and other nutrition improvement areas by aiding monitoring and compliance efforts."

The report asserts that "every year, nutrition-related diseases kill tens of thousands of Canadians and cost the Canadian economy at least $7 billion" and notes that the federal government's Advisor on Healthy Children and Youth projected that in 2000/01, obesity cost "Canada's health system an estimated $4.3 billion; $1.6 billion in direct costs such as hospital care, drugs, and physician services and $2.7 billion in indirect costs, such as lost earnings due to illnesses and premature deaths associated with obesity." The report also notes that the "World Health Organization estimates that preventable nutrition-related diseases in high income countries are responsible for one-fifth of all deaths, or nearly 48,000 deaths annually in Canada, due mainly to cardiovascular disease, diabetes, and certain cancers caused by excess sodium intake, risky blood cholesterol and glucose levels, inadequate fruit and vegetable intake, and excess abdominal body fat." — Wayne Kondro, *CMAJ*

Cholera cases vastly underreported

The global burden of cholera may be on the order of three million people per year, rather than the officially reported tally of approximately 317 000 in 2010, while the annual death toll may top 100 000 rather than 7543, according to a new World Health Organization (WHO) study.

Confirming the proposition that estimates of the number of reported cases of cholera worldwide capture but 5%–10% of the actual number of annual cases, the study also indicates that there are 51 countries in the world (https://trdrdcsys.ivi.int/cic/appendixA

.pdf) in which cholera is endemic, i.e., reported cholera cases in at least three of five years between 2003 and 2008. Another 18 countries reported cases but did not meet the criterion for endemic cholera status.

Current global estimates of the incidence of cholera are vastly underrepresented because of "inadequate laboratory and epidemiological surveillance systems and economic, social and political disincentives to case reporting," states the study, *The global burden of cholera* (www.who.int/bulletin/volumes/90/3/11-093427/en/index.html).

On the assumption that all residents of a country who lack access to "improved sanitation" are at risk of contracting cholera, the study concludes that 1.4 billion of the world's people are at risk, led by those living in Bangladesh, India and most nations of Africa. "An estimated 2.8 million [uncertainty range: 1.2–4.3 million] cholera cases occur each year in endemic countries, and the average global annual incidence rate is 2.0 cases per 1000 people at risk (range: 0.10–4.0). If the population not at risk is counted, the estimated average incidence in cholera-endemic countries drops to about 1.15 cases per 1000 population. The countries with the highest incidence rates are in Africa and southern Asia."

Over half of all cholera cases occur among children under age five, who also comprise about about half of the estimated 91 000 ("uncertainty range: 28 000–142 000") annual death toll from cholera, the study added.

Those numbers might be even higher if the assumption is made that all residents of China, India and Indonesia are at risk (rather than just those who lack access to improved sanitation), in which case, "the global cholera burden estimates increased to 5.1 million cases and 156 000 deaths."

The authors also indicated that their estimates did not include numbers from the cholera epidemic that ensued in Haiti following the destructive earthquake that the country suffered in 2010. Moreover, "we tried to be conservative in our estimates by defining the population at risk of cholera using the UN [United Nations] Millennium Development Goals Indicators database on country-specific access to improved sanitation and assuming zero incidence in the population not at risk." — Chris Hemond, Ottawa, Ont.

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