We suggest that when OAC [oral anticoagulant] therapy is indicated, most patients should receive dabigatran, rivaroxaban, or apixaban, … in preference to warfarin. This recommendation places a relatively high value on comparisons with warfarin.[3]

We suggest that readers consult the 2014 update of the atrial fibrillation guidelines when they become available.

Since 2010, four randomized controlled trials have provided high-quality evidence reflecting the safety and efficacy of direct-acting anticoagulants. This breadth of evidence includes over 70 000 patients. Both dabigatran and apixaban have been shown to be superior to warfarin in stroke reduction. In the Aristole trial there was a significant mortality benefit of apixaban compared with warfarin.[4] All of the newer anticoagulants significantly reduced the risk of intracranial hemorrhage.[5]

We agree that guidelines and published studies do not replace clinical judgment, and that individual practitioners should discuss with their patients the risks and benefits of all anticoagulants and take into account patient values and preferences.

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How can we best address the tuberculosis epidemic?

I read with interest the excellent *CMAJ* commentary by Campbell and colleagues,[1] in which the authors highlight the limitations of current tuberculosis (TB) control strategies for immigration screening.

There has been some recent progress. A new short-course regimen for latent TB infection, which requires just three months of once-weekly rifapentine and isoniazid (3HP), has been shown to be as effective, and perhaps safer, than the existing nine-month regimen of daily isoniazid.[2] Many of us, if given a choice, would prefer the 3HP regimen of 12 weekly doses compared to 270 daily doses of isoniazid. Unfortunately, although 3HP has been adopted as a treatment option for latent tuberculosis infection in the United States since 2011, access to this regimen is extremely limited in Canada.

As White and Houben[3] wrote in a recent editorial, the most direct and equitable way to progress toward elimination of TB in industrialized countries would be to increase funding for TB control in high-burden countries. In 2005, researchers from Montréal, Quebec, showed beautifully that this approach would not only lower rates of TB but, unlike increasing testing and treatment for latent TB infection, would lead to significant cost savings.[4] As Canadians, we have long been proud supporters of global TB control efforts and our international partnerships and aid efforts must continue.

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Vaporizer legalization

I agree with Kahan and Srivastava[1] that as physicians, we cannot support the smoking of cannabis, for either recreational or medical purposes. Even though a recent, large case–control study[2] showed no increase in lung cancer related to smoking cannabis, vaporization offers a clear harm-reduction approach to cannabis consumption. Vaporization more efficiently extracts cannabinoids from plant material, decreases the products of combustion and can be used in institutional settings, as has been the case in hospitals in Sherbrooke, Quebec and Calgary.

Vaporizers can be effective harm-reduction tools. Only one vaporizer is currently approved by Health Canada, although its hefty price tag of $600 keeps it out of the reach of many patients. The use of vaporizers in Canada is also compromised by their illegal status. The import, export, manufacturing and sale of vaporizers in Canada contravenes section 462.2 of the Criminal Code.[3] This section also provides for a prison sentence of up to six months for the possession of cannabis-related literature, in all provinces except Ontario.[3]

Aside from advocating that this archaic law be repealed nationwide, we should be recommending vaporizers not only to our patients who are being treated with cannabis, but also for those who we know to be using it for recreational purposes.

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