Busse and colleagues[1] suggest. We do not recommend load-bearing MRI for clinical use in the investigation of low-back pain. We clearly state "evidence is insufficient to support widespread adoption."[5]

Busse and colleagues[1] refer to two randomized controlled trials that compare vertebroplasty to a sham procedure.[8,9] Both of these trials have been criticized as deeply flawed by many,[10] including an author of one of the trials.[11] The authors[1] ignore the larger and better designed VERTOS II trial,[12] consensus statements from the major societies and organizations representing those who actually perform the procedure, as well as the great preponderance of evidence in its favour.

Busse and colleagues[1] note the substantial controversy over the utility of selective nerve-root blocks and radiofrequency denervation for back pain. When evaluating the literature, one must be conscious of the significant heterogeneity that is inherent in terms of patient back-pain etiology. Interventional procedures likely will not be efficacious when indiscriminately applied to nonspecific back pain. Rather, a better understanding of the types of back pain may lead to the ability to selectively choose those who will benefit the most from particular procedures.

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***CMAJ* 2014. DOI:10.1503/cmaj.114-0041**

Clarification of Borod's comments about Bill 52

Physicians may be reluctant to grant interviews about complex issues and concerned that their thoughts may be oversimplified or misrepresented. The *CMAJ* news article about Bill 52[1] is a case in point. I was pleased that the definition of palliative care was changed to be consistent with the World Health Organization definition, to clearly state that palliative care "neither hastens nor postpones death." It should follow from this that euthanasia is clearly not part of palliative care. I expressed concern that Bill 52 would create more barriers to referral to palliative care — not because of "increased paperwork" but because patients would be reluctant to see physicians who actively terminate patients' lives. I also expressed concern that although using the term "palliative sedation" as opposed to "terminal sedation" is important, reporting medical acts such as sedation may lead to a reluctance to implement this therapy. My comments were specific to the role of palliative care with regard to Bill 52. To be clear, I do not think that euthanasia or "aid in dying" has any place whatsoever in the practice of palliative care.

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***CMAJ* 2014. DOI:10.1503/cmaj.114-0042**

Post-tussive carotid artery dissection: Could it be whooping cough?

I thank Furlan and Sundaram[1] for their interesting case report on a patient who experienced a carotid artery dissection and subsequent Horner syndrome from coughing. I would like to remind clinicians that such a post-tussive injury should prompt consideration of pertussis as an underlying cause.

The cough caused by *Bordetella pertussis* infection is especially violent and can cause a variety of post-tussive injuries. Carotid artery dissection as a complication of pertussis has previously been reported.[2] Other potential symptoms and injuries secondary to pertussis include prolonged cough, seizures, syncope, encephalopathy, urinary incontinence, rib fracture, pneumothorax, inguinal hernia, subconjunctival hemorrhage, hearing loss and lumbar disc herniation.[2] In my emergency medicine practice, I have also seen pertussis cause vocal cord dysfunction, post-tussive vomiting and valsalva retinopathy.

The incidence of pertussis has been increasing since 1990.[3] We must remain vigilant for it in cases of unusual injury secondary to coughing.

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***CMAJ* 2014. DOI:10.1503/cmaj.114-0045**

Unusual venous thrombosis

In a *CMAJ* practice article, Schattner[1] provides guidance regarding when to test for thrombophilia and when to screen for occult cancer in patients with unprovoked venous thromboembolism (VTE). This issue is important, because unprovoked VTE is common (about