

20 000 cases a year in Canada),² and indiscriminate thrombophilia testing and extensive cancer screening occur frequently in clinical practice. We wish to emphasize two points. First, thrombophilia testing should be avoided because it does not affect clinical management in most patients.^{3,4} Even if a thrombophilic abnormality is found, such as the factor V Leiden or prothrombin mutation, its presence does not affect risk for recurrent VTE and, therefore, does not affect decisions about continuing or stopping anticoagulation therapy. Exceptions to this premise occur; the antiphospholipid antibody syndrome or protein S or C deficiency will warrant long-term anticoagulation, but such cases are rare (< 5%). Overall, testing for thrombophilia rarely affects patient management, often yields false positive results and may adversely influence insurability of patients. We urge clinicians to consult colleagues with expertise in thrombosis before testing for thrombophilia.

Second, although screening for cancer (i.e., abdominopelvic CT, colonoscopy) may increase the number of cancers detected, it does not appear to improve cancer-related mortality, morbidity or quality of life.⁴ Moreover, such screening may incur procedure-related complications and psychological burden from false positive results.⁵ Ongoing randomized trials are assessing the risks and benefits of comprehensive screening for cancer in unprovoked VTE (NCT00773448, NCT01107327). In the meantime, we suggest age- and sex-appropriate screening for cancer, with additional testing only if patients have symptoms that are suspicious for malignant disease.

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The benefit of stimulants in reducing driving risk in adult drivers with ADHD

Redelmeier and Tien¹ have provided an excellent update on the medical interventions to reduce driving risk. A recent article by Chang and colleagues² from Sweden may be of interest to *CMAJ* readers. The authors reported on an epidemiologic study between 2006 and 2009 of over 17 000 drivers with attention-deficit/hyperactivity disorder (ADHD). The hazard ratio for serious motor vehicle collisions for drivers with ADHD was 1.47, for males and 1.45, for females. The authors observed a 58% risk reduction in motor vehicle collisions involving male drivers with ADHD who took stimulants over the three years of the study. However there was no apparent benefit for female drivers with ADHD. The association between ADHD and increased driving risk, and the protective benefits of stimulants when driving has been documented.³ The *CMA Driver's Guide: Determining Medical Fitness to Operate Motor Vehicles. 8th Edition* includes

ADHD as a reportable condition if there is demonstrated problem driving.⁴ Physicians are encouraged to consider a trial of long-acting stimulants in reducing driving risk. The article by Chang and colleagues² provides more support for this medical intervention in drivers with ADHD and problem driving.

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Letters to the editor

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CORRECTION

"Pharmacist-led group"

A research article that appeared in the May 13, 2014, issue of *CMAJ* contains an error in the last sentence of the Results section, under the heading "Other outcomes." The sentence should read "At 6 months, 58.9% of patients in the pharmacist-led group [not the physician-led group] were taking a statin (32.7% at maximal daily dose) compared with 56.3% (25.8% at maximal dose) in the nurse-led group ($p = 0.7$ for usage, $p = 0.2$ for dosing)." *CMAJ* apologizes for this error.

Reference

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