Lyme law: targeting best practices

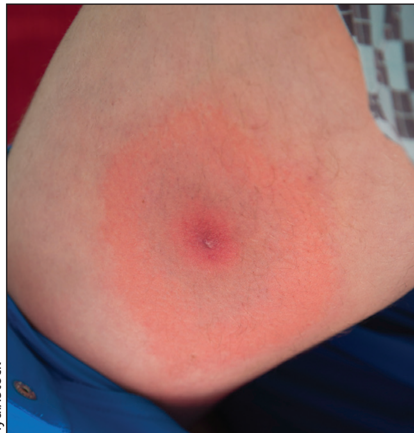
In her defence of the alternative views on Lyme disease diagnosis behind Bill C-442, Zubek[1] is certainly right to focus on the patients in her response to *CMAJ's* article on Lyme disease.[2] Many people who are under the impression that they have Lyme disease based on alternative approaches to diagnosis are disabled and in need of an open-minded approach to care. What will not help is a flawed diagnosis.

Lyme disease is making ecological inroads in Nova Scotia, southern Ontario and elsewhere, but Zubek writes from British Columbia. From her letter, one might think Lyme disease is everywhere, regularly missed, and that all we have to do to sort things out is employ alternative testing from specialty laboratories in the United States or diagnose Lyme disease based on any array of nonspecific findings.

In actual fact, ticks of all stages are under regular surveillance in BC using methods capable of detecting all strains of *Borrelia* with sensitive polymerase chain reaction methodology.[3] As in the 1990s, only 1 in 200 Ixodes ticks in the province carry the pathogen, it is the standard North American strain, and this prevalence remains 50- to 100-fold less than in highly endemic areas in the US Northeast.

Henry's observations[4] that family physicians do treat enlarging circular rashes as Lyme disease means that we have considerable vigilance on the front line, but given the broad array of dermatologic entities that may cause such a rash, also implies that an appropriate degree of overtreatment is going on, not that every case is Lyme disease. In the area of testing, a definitive study has shown that "specialty labs" not only failed to perform better than reference laboratories in finding *Borrelia* infection, but also, outrageously, labelled more than 50% of healthy controls as having it.[5,6]

The term junk science applies when one holds onto a nontestable hypothesis, fails to test it and expects one's critics to do so. In 2015, we should not state that a clinical diagnosis based, not on specific *Borrelia*-associated pathology, but on any array of nonspecific symptoms, is the best we can do.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I welcome Zubek's advocacy for a stronger model of patient care for people with difficult chronic symptoms, but note that flawed and premature conclusions about etiology hurt the very patients we are trying to help.

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Carter v. *Canada*

We applaud *CMAJ*'s efforts at advancing the discussion on physician-assisted suicide; however, we take exception to several of the points presented in Downey's commentary.[1]

First, this issue is not about physicians balking at oversight, it's about physicians being asked to do something contrary to their current practice. Let's not turn this into something more convoluted.

Second, Downey states that much may be learned from the experience of others, including palliative care physicians.[1] Is the suggestion that palliative care physicians represent the de facto group to advance physician-assisted suicide? Let's be clear that palliative care physicians have stated that they do not want to be associated with physician-assisted suicide.[2] Our focus is to relieve suffering, not to terminate life. Many of our patients already view the palliative care team as the grim reaper service. Adding a clear association with physician-assisted suicide will only exacerbate this.

Third, Downey states that both new and experienced physicians will need to learn how to deliver assisted dying. The number of patients requesting assisted suicide is very small. Do we want to spend considerable time and resources teaching medical students and experienced physicians an "intervention" that the vast majority will never carry out? A group of providers who want to do this will need to be identified and receive appropriate training and regulation.

What is truly needed is better access to palliative care training for both trainees and experienced physicians. Palliative care is given only minimal consideration in current medical school curricula, and yet, the vast majority of physicians will at some point be responsible for the care of patients near the end of life. Let's put our resources where we can make a meaningful impact for the vast majority of our patients.

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De-inking and docs

There are a few points in Collier's article on tattoo removal[1] that I must point out in the interests of accuracy:

- Using the second–degree-burn incident at Bye Bye Tattoo in Quebec to advocate for physician control over laser tattoo removal is misguided. The burns to the client were chemical in nature, not physical, and were caused by the injection of a chemical intended to "lift" or "dissolve" ink embedded in the skin. This story illustrates what we can expect if laser tattoo removal is made inaccessible to the general public. The public will continue to seek out unproven and dangerous options like chemical injection.
- Adding laser use to the list of restricted activities will not result in laser tattoo removal being performed strictly by regulated health practitioners. Restricted activities only apply in the context of providing a health service. There is simply no defensible argument that laser tattoo removal and other cosmetic laser treatments performed by estheticians or tattoo artists are somehow health services.
- The assertion that because these are cosmetic procedures they somehow fall outside of a health ministry's purview shows poor recognition of the larger public health family to which physicians belong. Ministries of health absolutely have an interest in cosmetic services. This is evident from the prevalence of personal-service legislation throughout the country. For decades, public health inspectors in Canada have successfully inspected personal service activities like body piercing, tattooing, permanent makeup, acupuncture, electrolysis and chemical skin treatments. Their track record tells us that they would be ideally suited to bring increased safety to cosmetic laser services.

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Overall, the article[1] asks a relevant and timely question, but ends up being myopic in its scope by intimating that the field of medicine is the best profession to provide the answer. No one would disagree with Collier's argument that calls for regulation, oversight and a complaint mechanism around the use of cosmetic lasers. However, since medicine cannot regulate outside of its own profession, medical professionals are better suited in this scenario as advocates for change. The question is not, "Should medicine take over tattoo removal," but, "How can medicine advocate for better outcomes?"

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Heart failure guidelines fail

We read with great interest the two articles regarding heart failure with reduced and preserved ejection fraction that highlight common and practical issues faced by patients and clinicians.[1,2] However, we were surprised to see that the first of these articles[1] did not mention the Canadian Cardiovascular Society Heart Failure Guidelines, available in print, online (www.ccs.ca) and in app format. These guidelines are the national source for Canadian practitioners and were designed and written for a Canadian audience.

Indeed, the authors should be aware that a recent guideline[3] and a focused guideline update in 2014[4] covered this topic in detail. Had the authors been aware of the former and corrected their article regarding the latter, they would have been aware of the guidance regarding spironolactone:

> We suggest that in individuals with HFpEF, an increased NP [natriuretic peptide] level, serum potassium < 5.0 mmol/L, and an estimated glomerular filtration rate (eGFR) ≥ 30 mL/min, a mineralocorticoid receptor antagonist like spironolactone should be considered, with close surveillance of serum potassium and creatinine (Weak Recommendation; Low-Quality Evidence).

The second of these articles[2] incorporates the guidelines correctly.

Finally, it behooves all authors (and editors) to ensure appropriate and relevant local information is conveyed, while ensuring that international science and guidelines are also incorporated. It is our belief that this means inclusion of Canadian data and guidelines for a medical publication that has a principal readership that is Canadian.

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Letters to the editor

Letters have been abbreviated for print. See www.cmaj.ca for full versions and competing interests.