

Drugged driving

In a *CMAJ* news article¹ Wanniarachige states that it is difficult to establish a dose–effect response between cannabis use and driving risk. A review of the literature by Ramaekers and colleagues² concludes that the “degree of performance impairment observed in experimental studies after doses up to 300 µg/kg THC [tetrahydrocannabinol] were equivalent to the impairing effect of an alcohol dose producing a blood alcohol concentration ≥ 0.05 g/dl, the legal limit for driving under the influence in most European countries.”² Ramaekers and colleagues note that “[s]ignificant performance impairment emerges at serum THC concentrations > 2 ng/ml and crash risk significantly increases at serum THC concentrations between 4–10 ng/ml.”² They observe that “combined use of THC and alcohol produces severe driving impairment and sharply increases the risk of drivers’ accident culpability as compared to drug-free drivers even at low doses.”²



Deirdre Rusk/istock

A link exists between attention-deficit/hyperactivity disorder (ADHD) and driving risk.³ The Dunedin study presents data on the effects of chronic frequent cannabis use starting in the teen years, showing toxic effects on cognitive neurodevelopment, which produce irreversible clinical syndromes indistinguishable from ADHD, and apparently irreversible loss of IQ, even after discontinuation of cannabis.⁴ This merits careful study by those advising legislators about the risks of intoxicated driving.

Laurence Jerome MBChB MSc
Western University, London, Ont.

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Bariatric surgery saves lives

Fletcher and Patrick suggest that the use of bariatric surgery “is always going to be limited and a last resort.”¹ I disagree. Bariatric surgery has a major impact on type 2 diabetes.² Over 6000 bariatric surgeries are performed annually in Canada, one-third in Quebec alone.³ If the United States is any indicator, we should be doing 20 000–25 000 surgeries per year.

Many Canadians go very south of the border (Mexico, Dominican Republic, Costa Rica, Brazil), where surgery is often performed in facilities whose conditions are unknown. Many patients come home with complications, resulting in a much higher cost to taxpayers.⁴

It is possible to increase the number of Canadian operations to 50 000–60 000 per year, and have 1% of the population treated within seven years. The investment would be recouped within three to five years.⁵ At present, bariatric surgery is the only proven treatment for severe obesity as societal changes are unlikely to have an impact in the next decade.⁶

Michel Gagner MD

Hôpital du Sacré-Coeur, Montréal, Que.

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Radon risks

I thank *CMAJ* for highlighting the topic of radon-related cancer.¹ Very few Canadians are aware of radon and the risks it poses. This is a substantial hurdle in the battle against radon-related malignancy. There is another hurdle: many physicians do not fully understand the risks related to radon.

The topic of radon was mentioned briefly during my medical school training. I did not pay much attention to it, given the vast number of other topics I had to learn. I suspect most of my colleagues did the same. Of the thousands of patient encounters in which I have been involved, I’ve never heard a physician ask about radon, nor have I.

Excellent resources are readily available. Health Canada’s website (www.hc-sc.gc.ca/ewh-semt/radiation/radon/index-eng.php) is an excellent introduction and should be required reading for all medical students and residents.

Michael Paci MD CM

Department of Neurology and Neurosurgery, McGill University Health Centre, Montréal, Que.

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Letters to the editor

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