

Would e-cigarette regulation alone improve adolescents' health?

I read with interest the *CMAJ* article on adolescent e-cigarette use.¹

That study concluded that e-cigarette use among adolescents is a serious public health problem and that regulation is the best strategy to curtail increasing e-cigarette use by adolescents. However, a recent study from the Yale School of Public Health shows that this measure can have unintended and dangerous consequences.² The results show that banning e-cigarette sales to minors actually increases their use of conventional cigarettes. We may need to carefully rethink an e-cigarette regulation strategy.

I am an adolescent, and I strongly believe that adolescents are puzzled by the common-sense validity of a proposal for a stricter regulation to limit the availability of e-cigarettes. Further, I doubt that this strategy alone would be effective. Even though certain laws limit face-to-face sales of e-cigarettes to adolescents, there is much less oversight online.^{3,4} Although most websites say buyers must be at least 18 years old, I know that adolescents and underage buyers can successfully place orders online. Moreover, online sales and targeted marketing are pushing adolescents toward e-cigarette use.⁵

Comprehensive prevention programs targeting adolescents are urgently needed in Canada. They need to be launched with the collaboration of schools, school boards, school administrators, parents, caregivers and youth organizations.

Getting adolescents involved in this prevention program is crucial and the key to success. I urge *CMAJ* to take a leadership role in a Canada-wide comprehensive school prevention program. We could perhaps tailor e-cigarette prevention programs similar to the old combustible cigarette prevention education programs.

We need an effective social media campaign to enhance adolescents' knowledge about the ingredients in e-cigarettes, their potential adverse effects and the known health hazards of prolonged use and misuse. There also needs to be a strong public education and awareness campaign to counter common myths and misconceptions (e.g., like e-cigarettes are a therapeutic tool).

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Well-placed advocacy

Tyndall has provided a thoughtful commentary on hepatitis C treatment and is duly respectful of nonmedical determinants of health, which are heavy influences on hepatitis C epidemiology.¹ As a physician providing frontline care for patients with this disease, I caution against presuming scarcity and approaching this problem with a treatment-or-prevention paradigm. We've applied this paradigm in the past with HIV and drug-resistant tuberculosis, only to find that treatment is actually a very good weapon in the prevention arsenal.

Although Tyndall does advocate for resources to be spent "upstream" at the level of prevention and addiction treatment, he does not recognize that finding a way to treat *all* cases of hepatitis C would be part of a complete

prevention and harm reduction strategy. We must avoid the trap of assuming that we are slaves to limited resources, and instead continually seek innovative ways to provide our patients with the standard of care. As a service provider to Canada's most vulnerable people, who are already at an increased risk of suffering (poor, homeless, indigenous, women and children suffering from abuse, mentally ill), I am compelled to find ways to provide even better care than the standard to my patients.

Yes, the new hepatitis C treatment regimens are expensive. Does that mean we should ration those treatments based on cost, or fight hard for a fairer price and good access for all? I am going to place my advocacy where it belongs: with the latter.

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What were incentive payments accomplishing?

I read with interest the analysis of incentive payments to family physicians in British Columbia for treating patients with chronic disease.¹

The study's finding of no health care outcome changes supports my own observations: those of us who have chosen family practice as a career want to do a good job, regardless of whether there is an incentive payment attached.

It was no surprise that measures of patient outcomes have not changed. I believe that there was another valid reason for initiating incentive payments — to support full-service family practice as a whole. The main change I have witnessed has been in the career choices made by new graduates since the incentive programs have been fully opera-

tional. In the decade before the incentive fees, our communities had no trouble finding physicians to staff walk-in shifts, and many new graduates were deciding to do hospitalist work because they viewed financial disincentives to entering full-service family practice. Family physicians who loved their practice were choosing to take half days off to work in a walk-in clinic just to be financially competitive with their colleagues.

I have watched a gradual shift this decade whereby physicians are back in their offices, and new grads are coming to communities to set up a full practice. I believe this is a direct result of BC incentive payments allowing doctors to choose to practise long-term comprehensive medicine on a financially equitable playing field.

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National opioid crisis

Friesen and colleagues¹ have provided invaluable insight into unsafe opioid prescribing in Canada over a time when we have seen unprecedented increases in prescriptions for opioids² and consequently the number of associated harms, including death.³

As an opioid prescribing educator, I agree with Lucyk and Nelson's contention in their linked commentary⁴ that we require improved prescriber education. However, given the breadth of the crisis, our approach to unsafe prescribing needs to be far more comprehensive, rational and coordinated.

An excellent example of the disconnectedness of our current efforts comes from British Columbia and the decision of its regulatory college to set new standards for opioid prescribing for chronic noncancer pain based on the

recently released guidelines from the Centers for Disease Control and Prevention.⁵ These new standards include what essentially amounts to a maximum dose of 90 MEQ (milligrams of morphine equivalent). Yet, as just one example, that province's formulary still carries transdermal fentanyl in doses more than four times this maximum in the form of 100 µg fentanyl patches (400 MEQ).

We know that decisions about what is available on formulary influences prescribing practices.^{2,6} With multiple inconsistent factors influencing prescriber behaviour, how can we expect a consistent response from physicians? In no other area of medicine do we see, or would we tolerate, such divergence and inconsistency of prescribing practices.⁷

As we continue to recognize the lack of good evidence for the use of strong opioids in chronic noncancer pain (despite what Lucyk and Nelson claim about the effectiveness of fentanyl⁴) and the substantial harms associated with their use, it is time that policy-makers, regulators, educators, prescribers and the public come together to form a consistent, rational and safe approach to the use of these potent medications.

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Nasal irrigation

Little and colleagues show a modest effect of nasal irrigation in people with recurrent or chronic sinusitis.¹ Participants used a neti pot, which delivers the irrigation fluid to the lower part of the nasal cavity.

However, the openings of the sphenoid, ethmoid and frontal sinuses are located at the top of the nasal cavity. Irrigation can only reach these openings when the head is positioned upside down. This can be achieved by instilling the irrigation solution from a syringe, with the head in supine position and then tilted backward into nearly an upside down position, over the edge of a bed or over an exercise ball. When the person sits up, the liquid is drained into a bowl, aided by a vigorous outbreath through the nose. A 60-mL syringe allows for five instillations of c. 12 mL each in a few minutes.

This procedure can be repeated daily when sinus symptoms are present. Liquid spilled over the face needs to be wiped quickly, before it reaches the eyes, lest purulent nasal material cause conjunctivitis. Water should be chlorinated or boiled and cooled to prevent infection, including amoebic meningoencephalitis.²

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