Letters
Correspondance

Diabetes in aboriginal populations

Contrary to John Anderson's claims,[1] diabetes in aboriginal populations has nothing to do with socioeconomic factors, nor can alleged genetic characteristics explain the high prevalence of diabetes in these populations, as the case of American and Mexican Pima Indians patently demonstrates. Pima Indians living in the United States are ravaged by diabetes, whereas those who live in Mexico, despite their lower socioeconomic status, are free of diabetes.[2] Therefore, the prevalence of this disease in American Pima Indians can only be ascribed to the fact that they consume Western foods not in their traditional diet, which are unavailable to their Mexican counterparts. These "genetically unknown"[3] foods are rich in fat and contain sucrose in solid form or in concentrations exceeding the physiologic limit imposed by evolution.[4]

A group of Australian Aborigines virtually recovered from diabetes in 5 weeks by returning to their traditional diet.[5] Similarly, a group of obese Hawaiians lost an average of 7.8 kg each in 3 weeks by consuming their traditional foods to satiety, without changing their sedentary lifestyle.[6]

Rather than continuing to look for putative genetic mutations responsible for diabetes epidemics in aboriginal populations after their contact with Westerners, it might be more rewarding to look for genetic mutations that confer relative resistance to diabetes in Westerners, despite their consumption of some diabetogenic foods that humankind is genetically unequipped to handle.[7]

Riccardo Baschetti
Family physician
Padua, Italy

References

1. Anderson JF. Diabetes in Aboriginal populations [letter]. *CMAJ* 2000;162(1):11.
2. Fox CS, Esparza J, Nicolson M, Bennett PH, Schulz LO, Valencia ME, et al. Is a low leptin concentration, a low resting metabolic rate, or both the expression of the "thrifty genotype"? Results from Mexican Pima Indians. *Am J Clin Nutr* 1998;68:1053-7.
3. Baschetti R. Genetically unknown foods or thrifty genes? [letter]. *Am J Clin Nutr* 1999; 70:420-1.
4. Baschetti R. Sucrose metabolism [letter]. *NZ Med J* 1997;110:43.
5. O'Dea K. Marked improvement in carbohydrate and lipid metabolism in diabetic Australian Aborigines after temporary reversion to traditional lifestyle. *Diabetes* 1984;33:596-603.
6. Shintani TT, Hughes CK, Beckham S, O'Connor HK. Obesity and cardiovascular risk intervention through the ad libitum feeding of traditional Hawaiian diet. *Am J Clin Nutr* 1991;53: 1647S-51S.
7. Baschetti R. Diabetes epidemic in newly westernized populations: Is it due to thrifty genes or to genetically unknown foods? *J R Soc Med* 1998;91:622-5.

Technology list found wanting

I must address some of the inequities and inaccuracies in Caralee Caplan's editorial in *CMAJ*'s technology issue.[1] In her description of how a list of current technologies in medicine was generated, she commented that she polled people in 34 clinical specialties. As a result, she presented a list in which a substantial number of the new technologies ascribed to certain disciplines actually are imaging or interventional technologies that are performed largely by radiologists. Further, interventional radiology and interventional neuroradiology, subspecialties in their own right, were not even mentioned. It is insulting in this day and age that diagnostic imaging was not considered to be a clinical specialty and that many of the procedures performed by radiologists were categorized by other physicians as being under the purview of their specialty. I realize that to some this may seem like hairsplitting and turf protection, but in an endeavour such as this to catalogue many of the emerging technologies that will have an impact on medical practice I believe appropriate attribution of the technology and technical skills is important. To include angioplasty and stenting of carotid arteries under the heading cardiology or to include functional MRI, SPECT scans, intra-arterial thrombolysis and endovascular coiling of aneurysms under the heading neurology, neurosurgery and vascular surgery is insulting and demeaning to the radiologists across the country who perform the bulk of these procedures. I would encourage Caplan to update her email list to include clinical specialists in diagnostic imaging.

Robert Ashforth
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Reference

1. Caplan C. A technological journey: specialty spotlights and beyond [editorial]. *CMAJ* 1999; 161(9):1124-7.

I read with interest Caralee Caplan's attempt to chronicle recent technological advances in medicine.[1] I was disappointed, however, to note the lack of a section dealing with geriatric medicine. Given the changing demographics of the population, seniors are certainly going to continue to be beneficiaries of advances in diagnostic and therapeutic technology. I proffer my own incomplete list in this regard, hoping that more erudite readers will add to the list (Caplan mentioned some of these items under other specialties and subspecialties): advanced neuroimaging in dementia, newer and more accessible methods of bone-density measurement, cognition-enhancing pharmacotherapy, intelligent drug-monitoring computer systems to decrease or prevent adverse drug events, electronic mobility aids, electronic antiwandering devices and safe environments for habitual wanderers, and computerized gait-analysis devices to prevent falls.

Shabbir M.H. Alibhai
Geriatrician
University Health Network
Toronto, Ont.

Reference

1. Caplan C. A technological journey: specialty spotlights and beyond [editorial]. *CMAJ* 1999; 161(9):1124-7.

[The author responds:]

Robert Ashforth and Shabbir Alibhai have underlined some of the difficulties inherent in creating a list of technologies using a computerized reviewer database and email. First, my initial survey was limited to those reviewers with accurate email addresses in the database. Second, *CMAJ*'s reviewer database includes only a small fraction of Canada's specialists, and certain specialties are clearly underrepresented. For example, of reviewers with email addresses in the database, there are 64 specialists in hematology–oncology, 14 in gastroenterology and only 13 representing radiology and nuclear medicine combined.

Furthermore, with space limitations in the journal, the challenge was to keep the list as complete as possible without being repetitive. Thus, specialties dealing with similar disease processes were combined under 1 heading. Although inhaled nitric oxide for hypoxemic repiratory failure was listed as a critical-care technology, it could just as easily have been described as a technology "belonging" to respirology. Similarly, telemedicine, a technology with important applications in many medical fields, was listed under the heading cardiology and cardiac surgery simply because several cardiologists cited telemedicine as a key development.

In this vein, my choice not to include diagnostic imaging as a heading was certainly not an attempt to attribute radiologic technologies and skills to other specialists, but was rather an effort to show the wide-ranging applications of imaging technologies in virtually all areas of the body and of medicine. As I emphasized in my editorial, new imaging techniques have changed the way we see disease, and technological advances in radiology have had an impact well beyond the bounds of a single specialty.

The list is by no means comprehensive. It was meant to give readers a sense of the directions technology has taken, to be a springboard for more detailed descriptions and to serve as an invitation to specialists, like Ashforth and Alibhai, to tell us more about what they do.

Caralee E. Caplan
Former *CMAJ* editorial fellow
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A new register for clinical trial information

I applaud David Hailey for recognizing that "Schering Health Care and Glaxo Wellcome have taken important steps in making information available about ongoing trials in which they are involved."[1]

Having recognized the need for global access to information, Glaxo Wellcome recently introduced a clinical trials register to ensure that as much information as possible is available to researchers and clinicians. The goal is to facilitate systematic review of late-stage clinical data and, ultimately, to improve patient care.

Researchers already have access to much clinical trial information because the submission of clinical trial reports to peer-reviewed journals has long been established as a means of subjecting data to the rigorous scrutiny of the medical community. However, not all data generated through the drug-development process are published, meaning that an unpublished pool of potentially valuable data exists.

Medical researchers and other health care professionals can access the clinical trials register through a password-protected area of the Glaxo Wellcome external R&D Web site (www.glaxowellcome.ca). The site allows users to access our study protocols and unpublished late-stage clinical trial data when reviewing information on specific medications. The register will also make researchers aware of research in progress, thereby avoiding duplication of effort.

In addition to establishing and maintaining the register, we remain committed to publishing clinical trials in peer-reviewed journals. Each trial in the register will be assigned a unique identifier, which researchers can use to link each publication back to the original trial. Because a single trial may generate several publications, the unique identifier will help people reviewing the literature to identify specific trials and avoid duplication of trial data.

Because access to information about specific medications can improve patient care, Glaxo Wellcome has taken the lead in developing this clinical trials register for the use of medical researchers and clinicians. We encourage the rest of the research-based pharmaceutical industry to join us.

Michael D. Levy
Senior Vice-President, Research & Development
Chief Medical Officer
Glaxo Wellcome Inc.
Mississauga, Ont.

Reference
1. Hailey D. Scientific harassment by pharmaceutical companies: time to stop [commentary]. *CMAJ* 2000;162(2):212-3.

Migrants from China

I was upset to read the article "BC's Chinese migrants a healthy lot, MDs find."[1] The article stated that 34% of the passengers on the fourth boat had chronic hepatitis B, which means that these passengers are infective. If over one-third of them have a disease that, if transmitted, is life threatening, how can we call them a healthy lot? I find this outrageous. Even the outcome of the disease to the migrant and the cost to our medical system leave me wondering why our government allows this to continue.

Ann-Marie Robertson
Family physician
Vancouver, BC

Reference
1. Kent H. BC's Chinese migrants a healthy lot, MDs find. *CMAJ* 2000;162(2):256.

[The news and features editor

responds:]

The headline referred to the importance the "snakeheads" — the people who smuggled these migrants to Canada — placed on health status in choosing which people to bring. They did this because healthy migrants could pay them back faster. Even the chronic carriers of hepatitis B appeared to be in good health.

Patrick Sullivan

Red tape is strangling foreign-trained physicians

I would like to add my voice to that of Alex Porzecanski, whose letter lamented the lack of support for foreign-trained physicians.[1] Not only are there considerable stumbling blocks for these students, but there is considerable disincentive for them to return to Canada after their residency.

After completing my degree in a foreign medical school, I pursued a residency in Canada. I was met with a disheartening wall of bureaucracy and opted for a position in the US. At the end of my training and after completing the American Board of Internal Medicine (ABIM) exams, I inquired about practice in Canada. Even as a Canadian with American qualifications, I found that entry into the system was daunting.

At this point I am a graduate of a medical school recognized by the World Health Organization, have ABIM certification, hold 2 state licences and LMCC certification and practise in New Brunswick. Nevertheless, 3 years after embarking on a journey for the elusive Holy Grail of FRCPC certification, I'm being prevented from writing the Canadian exams. It seems that when every criterion has been met, a new form must be filled out or a new exam must be written. The latest roadblock is the requisition of my entire medical school transcripts in order to reinvent the wheel!

Therefore I have no sympathy for the governing bodies and medical societies that cry about physician shortages. This mess developed because of our own turf protection and short-sighted planning. The result is convoluted departments that justify their existence, and funding, by creating seemingly endless red tape.

I'm luckier than most, in that I can continue to work while wading through this quagmire of paperwork. But why are we surprised to learn that there has been a brain drain south when at home we have actively set out to exclude people from working here?

Ardavan Mahim
Internist
Miramichi, NB

Reference

1. Porzecanski A. Why do we force Canadians to study medicine abroad? [letter]. *CMAJ* 1999; 161(11):1389.

What exactly were you highlighting?

On the first page of the Jan. 11, 2000, issue of *CMAJ* there is a highlight[1] of a study published in that issue on HIV infection in young gay and bisexual men in Vancouver.[2] Accompanying the highlight is a photograph of 4 young children who by all appearances it can be safely assumed are African.

Could someone explain to me the connection between the photograph and the content of the article? What do 4 young African children have to do with HIV infection in Vancouver? It is said that a picture is worth a thousand words; what is this one telling us? Insensitivity can take many forms and this is one example of such.

W.S. Lofters
Department of Oncology
Kingston Regional Cancer Centre
Kingston, Ont.

References

1. Highlights of this issue. *CMAJ* 2000;162(1):1.
2. Strathdee SA, Martindale SL, Cornelisse PGA, Miller ML, Craib KJP, Schechter MT, et al. HIV infection and risk behaviours among young gay and bisexual men in Vancouver. *CMAJ* 2000;162(1):21-5.

On the highlights page[1] in the Jan. 11, 2000, issue of *CMAJ*, what is the relevance of the photograph under the headline "HIV complacency" to the synopsis or the articles described? Are the innocent children complacent about HIV, or were they the young gay and bisexual men in Vancouver?

I hope I am right in assuming that informed consent of the children and their parents was obtained for the photograph to (1) be taken and (2) be published without masking the faces.

Muri B. Abdurrahman
Pediatrician
Toronto, Ont.

Reference

1. Highlights of this issue. *CMAJ* 2000;162(1):1.

[Editor's note:]

The image was chosen to highlight editorialist Brian Willoughby's[1] concern for populations, such as children in sub-Saharan Africa, who face the prospect and the toll of HIV infection and AIDS[2] with little hope of sharing in the pharmacological advances available in Europe and North America. *CMAJ* is committed to the policy of obtaining consent from patients before publication of personal and medical information about them. However, the issues that surround this policy can become complex, and one might reasonably expect to run into grey areas from time to time.[3] In the present case, the image was taken from a stock photo library and was used to draw attention to a population at risk. There was no disclosure of personal or medical information.

References

1. Willoughby BC. HIV: the millennium bug. *CMAJ* 2000;162(1):52-3.
2. Mukwaya J. The AIDS emergency. In: *The progress of nations 1999*. New York: UNICEF; 1999. Available: www.unicef.org (accessed 2000 Feb 22).
3. Hoey J. Patient consent for publication — an apology. *CMAJ* 1998;159(5):503-4.

It's uncanny

In choosing to illustrate your article[1] with — horror of horrors — a photo of canned commercial chicken soup, you have made a monumental error. The authors are Israeli, which should have been a clue. As any of your Canadian Jewish colleagues could have told you, only mother's authentic homemade chicken soup qualifies as a panacea for all of mankind's ills.

William E. Goodman
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Freelance author, public speaker
Toronto, Ont.

Reference

1. Ohry A, Tsafrir J. Is chicken soup an essential drug? *CMAJ* 1999;161(12):1532-3.

I read with great interest the suggestion by Abraham Ohry and Jenni Tsafrir that chicken soup be considered an essential drug.[1] I endorse this recommendation on the basis of my interpretation of the medical writings of the renowned 12th century physician Moses Maimonides.

Ohry and Tsafrir quoted Maimonides' recommendations that chicken soup be used to treat leprosy, migraine, constipation and the "black humours" (an excess of which was thought to cause melancholy). In his *Medical Aphorisms*[2] Maimonides also made several other recommendations. He stated that the consumption of fowl is beneficial for feebleness, hemiplegia, facial paresis and the pain of edema and that it increases sexual potential. He advised that turtledoves increase memory, improve intellect and sharpen the senses and that house pigeons that graze in the streets increase natural body heat. Soup made from the bird called kanaber loosens cramps of colic. Chicken testicles provide excellent nourishment for a weakened or convalescent individual. Pigeon eggs are good aphrodisiacs, especially when cooked with onion or turnip. Soup made from an old chicken is of benefit against chronic fevers that develop from white bile, and it also aids the cough that is called asthma.

In his *Treatise on Asthma*,[3] Maimonides advised asthma sufferers to consume the soup of chickens or fat hens. He strongly endorsed the use of an enema with sap of linseed, fenugreek or both, with oil and chicken fat and an admixture of beet juice, to treat asthma.

It thus seems evident that Maimonides, in the 12th century, gave scientific respectability to what the proverbial Jewish mother has always known — that chicken soup can help cure a variety of ailments.[4]

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at Queens Hospital Center
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References

1. Ohry A, Tsafrir J. Is chicken soup an essential drug? *CMAJ* 1999;161(12):1532-3.
2. Rosner F. *The medical aphorisms of Moses Maimonides*. Haifa: Maimonides Research Institute; 1989. p. 293-312.
3. Rosner F. *Moses Maimonides' treatise on asthma*. Haifa: Maimonides Research Institute; 1994. p. 176.
4. Rosner R. Therapeutic efficacy of chicken soup. *Chest* 1980;78:672-4.

[The authors respond:]

We couldn't agree more with William Goodman. The fact that chicken soup has been around for at least 2000 years implies that only the genuine article has true medicinal qualities, and not the precooked, synthetic or dehydrated upstart.

We thank Fred Rosner for his illuminating remarks. We had decided, for the sake of brevity, to refer only to his 1980 article in *Chest*, which contained the references to Maimonides' writings, but are grateful that he has now expanded the information to include fuller details of the therapeutic properties of chicken soup and of other fowl-associated remedies.

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Jenni Tsafrir
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Chaim Sheba Medical Center
Tel Hashomer and Tel Aviv University
Israel

Corrections

An error was introduced into a recent letter from Emile Berger[1] during copyediting. The date of publication of the third reference was 1999, not 1990.

Reference

1. Berger E. High marks for the physical exam [letter]. *CMAJ* 2000;162(4):492-3.

Owing to a copyediting error, the affiliation information for one of the authors of a recent *CMAJ* article was published incorrectly.[1] Susan Foster is with the London School of Hygiene and Tropical Medicine, which is affiliated with the University of London in Britain.

Reference

1. Clark WF, Churchill DN, Forwell L, Macdonald G, Foster S. To pay or not to pay? A decision and cost–utility analysis of angiotensin-converting-enzyme inhibitor therapy for diabetic nephropathy. *CMAJ* 2000;162(2):195-8.

In the article by Jaime Caro and colleagues on anticoagulation for patients with atrial fibrillation,[1] it was stated in the introduction that "warfarin is being prescribed for only about two-thirds of patients with atrial fibrillation." In fact, the 5 articles that the authors cited to support that estimate report rates that vary between 32% and 40%. The authors regret this inadvertent misrepresentation of the reported rates.

Reference

1. Caro JJ, Flegel KM, Orejuela ME, Kelley HE, Speckman JL, Migliaccio-Walle K. Anticoagulant prophylaxis against stroke in atrial fibrillation: effectiveness in actual practice. *CMAJ* 1999;161(5):493-7.