

Correspondance

example, the July 1996 and January 2000 editions of the *Adverse Drug Reaction Newsletter* provided safety information on cisapride.^{1,2}

The only TPP-approved information on drugs in Canada is provided in the product monograph. The TPP is revising the format and content requirements for product monographs; one component of the new monographs will be specific, Canadian patient information that could be provided when a product is prescribed or dispensed. On the basis of public consultations on the product monograph held in September 2000 (www.hc-sc.gc.ca/hpb-dgpps/therapeut/htmleng/consult_monograph.html), we are planning to electronically post product monographs in both official languages.

Health Canada recognizes the importance of communicating risk information concerning therapeutic products to health care professionals and consumers alike. I therefore urge *CMAJ* readers to consult our Web site to familiarize themselves with the progress on our initiative to improve the format and content of product monographs and to make their contents available to the Canadian public.

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References

1. Cisapride: arrhythmia awareness. *Can Adverse Drug Reaction News* 1996;6(3):1-2. [Also in *CMAJ* 1996;155(1):69-70.]
2. Morawiecka I. Cisapride (Prepulsid): interactions with grapefruit and drugs. *Can Adverse Drug Reaction News* 2000;10(1):1-2. [Also in *CMAJ* 2000;162(1):105-8.]

Fifty years at Western

I appreciated the lists of University of Western Ontario medical school students from 1954 and 2004 that you published in your 2000 holiday issue.¹ The changes that have taken place over the 50 years are obvious: we now have a larger number of students, more female

students and a greater ethnic mix within the student body. These differences reflect not only the increasingly multicultural nature of Canadian society but also the changing attitudes toward who should be admitted to medical school.

Women now account for 50% of Canada's medical students, compared with 5% from our class of 1954. It is worth noting that women were not accepted in any Canadian medical school just over 100 years ago.

Similarly, our schools now welcome candidates who reflect the ethnic spectrum of the population, and this range of cultural and ethnic backgrounds enriches everybody and helps ensure that our graduates will understand and respond appropriately to diversity within their patient population.

However, increased recognition of the value of inclusiveness in Canadian medical schools in no way detracts from the class of 1954, whose members have provided committed service and leadership to their profession for so many years.

Carol P. Herbert

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Reference

1. Fifty years at the University of Western Ontario. *CMAJ* 2000;163(12):1581.

Clinical examination for carpal tunnel syndrome

Thenar wasting is not mentioned in the *CMAJ* clinical update on carpal tunnel syndrome.¹ However, it may be obvious on one or both sides — particularly in elderly people — and it can even reduce the thenar bulk of the heavy labourer's typically more muscular dominant side so that it matches that of the other side. Thenar wasting is associated with detectable loss of muscle power. These signs are common, reliable and easily elicited at the bedside.

Alex MacIntyre

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Reference

1. Myers KA. Utility of the clinical examination for carpal tunnel syndrome. *CMAJ* 2000;163(5):605.

The clinical update on the utility of the clinical examination for carpal tunnel syndrome¹ is a review of a review. The original article highlights the pitfalls of using MEDLINE-based reviews to generate clinical practice guidelines.² The basic assumption of Kathryn Myers' clinical update is that electrodiagnostic studies represent the gold standard for di-

Submitting letters

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eLetters

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agnosis, an assumption the authors of the original article themselves admit is flawed.

Myers extracts the recommendation that “decreased pain sensation in the median nerve distribution is the most helpful finding in making the diagnosis.” This finding will only help to diagnose advanced carpal tunnel syndrome, in which the patient’s sensation at rest is impaired. Use of this finding will indeed increase the specificity of the examiner’s results but will seriously decrease the sensitivity of the clinical examination. If practitioners follow this guideline they will grossly underdiagnose carpal tunnel syndrome and will exclude many patients who would benefit from treatment.

Recent studies point to the carpal compression test as the most reliable and valid physical examination test for the diagnosis of carpal tunnel syndrome.³⁻⁵ The goal in recommending a clinical examination technique for the diagnosis of a disorder is both high specificity and sensitivity, and the carpal compression test is a markedly better way to achieve this goal than assessment of median nerve pain threshold.

Timothy J. Best

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References

1. Myers KA. Utility of the clinical examination for carpal tunnel syndrome. *CMAJ* 2000;163(5):605.
2. D’Arcy CA, McGee S. Does this patient have carpal tunnel syndrome? *JAMA* 2000;283:3110-7.
3. Marx RG, Bombardier C, Wright JG. What do we know about the reliability and validity of physical examination tests used to examine the upper extremity? *J Hand Surg* 1999;24A:185-93.
4. Marx RG, Hedak PL, Bombardier C, Graham B, Goldsmith C, Wright JG. The reliability of physical examination for carpal tunnel syndrome. *J Hand Surg* 1998;23B:499-502.
5. Mackinnon SE, Dellon AL. *Surgery of the peripheral nerve*. New York: Thieme Medical Publishers; 1988.

You say statistics, I say statistics

It may be an old fustbudget, but the advertisement for the editorial fellowship on page 1148 of the Nov. 28, 2000, issue of *CMAJ* would have had

more impact if “statistics” had been spelled correctly — especially as the 1998 Fellow said in the ad that she had learned about copyediting during her year with the journal. Having recently moved to Australia I enjoy reading *CMAJ*, but I could not resist a wee note to keep the copyediting division up to speed.

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[Editors’ note:]

Our faces are red with embarrassment ... er, embarrassment.

Email use by physicians

After reading the news item by Shelley Martin about the results of the 2000 Physician Resource Questionnaire¹ and reviewing the additional statistics on the CMA Web site² I suspect that there is bias in the statistics about computer use by Canadian physicians.

In Alberta, 49.5% of physicians have a known email address, according to the College of Physicians and Surgeons of Alberta and the Alberta Medical Association. This is 22.6% lower than the 72.1% figure quoted for email use among Canadian physicians in the “Internet use” section of the Physician Resource Questionnaire statistics.² I simply do not believe that Alberta physicians are that far below the national average in their use of computers.

I suspect that, as in past surveys, many respondents who do not use computers left the computer questions blank, rather than answering No. If such records were not used when calculating the overall percentages, the percentage of computer users would be falsely high. This might be due in part to the fact that the computer questions appeared at the end of a long questionnaire. I respectfully suggest that the

survey analysts compare their email usage figures with membership data from each provincial college of physicians and medical association.

Barrie McCombs

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References

1. Martin S. Almost all physicians have embraced computer use, survey shows. *CMAJ* 2000;163(8):1042.
2. 2000 CMA Physician Resource Questionnaire results. Available: www.cma.ca/cmaj/vol-163/issue-5/prq/index.htm (accessed 20 Mar 2001).

[The author responds:]

As in past surveys, the denominator in the calculation of the proportion of physicians who use computers and who use email is equal to the total number of physicians who completed the survey. All records, including those in which the physician left the email or the computer question or both blank, were used when calculating the overall percentages.¹

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Reference

1. 2000 CMA Physician Resource Questionnaire results. Available: www.cma.ca/cmaj/vol-163/issue-5/prq/index.htm (accessed 20 Mar 2001).

Correction

In Table 3 of a recent *CMAJ* article by Ruhee Chaudhry and colleagues, the 95% confidence interval for the 5-year survival rate for patients with a median neighbourhood family income less than \$45 000 who were initially seen in a teaching hospital should read 85.3–94.6, not 95.3–94.6.¹

Reference

1. Chaudhry R, Goel V, Sawka C. Breast cancer survival by teaching status of the initial treating hospital. *CMAJ* 2001;164(2):183-8.