

Correspondance

Total hip replacement: need far exceeds supply

Studies that assess the population requirement for treatment (i.e., the number of people who would benefit from evidence-based, effective treatment and would choose to accept such treatment) are rare because they are expensive and time consuming. We applied published estimates of the incident and prevalent requirement for total hip replacement in the United Kingdom¹ to the 1996 Ontario population aged 35 to 85 years.² We then compared this requirement with the actual provision of surgery, on the basis of data from the Canadian Institute for Health Information on hospital separations (procedure codes 93.51 and 93.59,³ excluding cases with a diagnosed fracture of the neck of the femur [code 820.0 of the *International Classification of Diseases*, 9th revision⁴]).

Given an incident requirement rate of 2.23 total hip replacements per 1000 people, we estimated that 12 088 people per year in Ontario require surgery for their hip pain. In 1996 the number of surgeries provided (6838) fell short of this estimate, by 43%. The prevalent requirement (i.e., the accumulated backlog of people requiring surgery) was much higher: 82 362 people.

Although this analysis has limitations, we believe that the approach is justified because the prevalence of self-reported hip pain is broadly similar in Canada and the United Kingdom^{1,5} and because the age distribution of the 2 populations is similar. We were unable to compare our estimates with the findings of an Ontario study⁶ because the researchers in that study combined hip and knee arthroplasty into one category and did not distinguish between prevalent and incident requirements.

Measuring the gap between the population requirement for health services and the provision of these services may be a useful way of identifying shortcomings in the delivery of care. Our results suggest that many

people in Ontario who experience severe hip pain are not receiving beneficial treatment.

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References

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Cisapride and the Vanessa Young inquest

A recent *CMAJ* editorial is misinformed in its statement that Vanessa Young's death was "undoubtedly caused by the drug cisapride."¹ We acknowledge *CMAJ*'s right to express an opinion about this matter, but readers should be given accurate, factual information, including the following.

On April 24, 2001, a coroner's jury concluded that Vanessa Young's arrhythmia and cardiac arrest resulted "from the effects of bulimia nervosa in conjunction with cisapride toxicity and possibly an unknown cofactor such as congenital cardiac defect." Significant evidence presented at the inquest from a variety of health care professionals indicated that it was highly probable that

Vanessa Young had risk factors for cardiac rhythm problems that could have caused her death independently of any medication she may have been taking.

Distribution of cisapride was stopped in Canada on May 29, 2000, whereas in the United States it was stopped on July 14 and inventory remained in pharmacies until mid-August. Pharmacies stopped selling the drug in Canada on August 2.

Cisapride was clearly contraindicated for people at risk of electrolyte imbalances, including those with bulimia, and this information had been included in the prescribing information for the drug for a number of years before it was prescribed to Vanessa Young. As early as 1995, Janssen-Ortho, Inc., began to send letters to physicians and pharmacists in Canada describing the occurrence of serious cardiac rhythm disturbances in certain patients who had taken the drug and highlighting changes to the prescribing information. This new information was also made available to physicians and pharmacists in the *Compendium of Pharmaceuticals and Specialties*. Physicians and pharmacists rely on prescribing information approved by Health Canada (which is published and updated in the *Compendium of Pharmaceuticals and Specialties* annually, among other places), not on patient leaflets, to safely and appropriately prescribe and dispense pharmaceutical products.

Consistent with our commitment to patient safety, we will continue to work closely with Health Canada and medical professionals to examine ways to optimize communication of new clinical findings and prescribing information.

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Reference

1. Lessons from cisapride [editorial]. *CMAJ* 2001; 164(9):1269.