

Correspondance

The accidental cell phone user

We were shocked and dismayed by *CMAJ's* recent call for regulation of cellular telephone use in cars.¹ Good legislation addresses clearly identified problems, is based on scientific evidence and can be enforced. The legislation *CMAJ* has demanded would meet none of these criteria.

Your assumption that wireless phones cause traffic deaths and injuries was apparently based on a study that made no claim to prove the devices cause collisions.² Moreover, the study had several shortcomings. First, the sample was small and biased: the study looked at 699 Toronto drivers, all of whom had a cell phone and had been in a collision without injuries. In contrast, a study released this year was based on a random survey of 36 000 drivers.³ Second, the data were from 1994–1995. Since then, the number of wireless telephone subscribers in Canada has quintupled, from 1.8 million at the end of 1994 to 9 million in March 2001, whereas the number of licensed drivers has increased by 10% and the number of vehicles by only 3%. Finally, the authors assumed that young urban professionals can be expected to have very low collision rates and very safe driving patterns. The opposite is true: young drivers have more collisions and tend to be more likely to take risks than older drivers.

A recent study found that distracted drivers accounted for about 9% of serious crashes.⁴ Of that number, 1.5% were using or dialing a cell phone at the time of the crash. In comparison, 11.4% were distracted by adjusting a radio, cassette or CD and almost 30% were distracted by an outside person, object or event.

Distractions can indeed be dangerous. However, laws against careless driving are already in place to prosecute drivers who do not make the driving task their top priority when using a wireless phone. For example, Ontario drivers who are caught driving carelessly while they are talking on cell phones, eating, reading or applying makeup are subject to a \$325 fine and the loss of 6 demerit points. Similar

penalties apply in jurisdictions across Canada.

Please don't compromise your journal's credibility by making frivolous demands for ill-conceived laws.

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Corticosteroids and avascular necrosis of the femoral head

Members of the Division of Orthopedics of St. Michael's Hospital in Toronto continue to maintain that a single short course of corticosteroid medication contributes to avascular necrosis of the femoral head.¹ They must be reminded that avascular necrosis was reported before corticosteroids were introduced. It remains a disorder of unknown origin. The list of patients in the article by Michael McKee and colleagues includes people at high risk for avascular necrosis, such as patients with increased intracranial pressure, alcoholism and trauma.¹ The authors' thinking is an example of guilt by association.

Short courses of corticosteroid therapy are widely used for life-threatening or disabling conditions, such as asthma, severe nasal polyposis, sinusitis and atopic dermatitis. The incidence of slightly over 1 case of avascular necrosis per year reported by the authors is tiny in comparison with the thousands of courses of corticosteroids appropriately prescribed over that time frame.

This report will embolden lawyers to sue physicians who appropriately prescribe short courses of corticosteroids to

patients who end up with avascular necrosis, even though the evidence for a relationship is weak. Patients should indeed be warned of the side effects of short courses of corticosteroid therapy, such as weight gain, mood swings, sleep disturbance, muscle cramps and even avascular necrosis, although the last of these is extremely rare. Clinical judgement remains paramount.

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[The authors respond:]

We agree with Allan Knight that avascular necrosis was reported long before corticosteroids were introduced and that it remains to some extent a disorder of unknown origin. There are cases of "idiopathic" avascular necrosis for which no precipitating or predisposing factor can be found. However, a multitude of clinical studies confirm that corticosteroids represent a risk factor for the development of this condition. In a previous study from our institution 63% of the cases of avascular necrosis were induced by steroid use.¹ At present, corticosteroids remain the single most common etiological factor for avascular necrosis seen in our centre.

Only 3 of the 15 patients in our series had other risk factors for avascular necrosis.² We included these patients in our article to illustrate the point that of the many patients who receive a short course of corticosteroid medication only a small percentage develop avascular necrosis. It is clear that some other predisposing condition or concomitant risk factor is responsible for the development of avascular necrosis.

We agree that short courses of corticosteroid therapy are widely used for