Public health capacity in Canada

W. Harding Le Riche is correct in suggesting that increasing public health capacity is an important challenge.[1] However, the suggestion that responsibility should be jointly supported by the academy and the Royal College of Physicians and Surgeons of Canada fails to recognize the government (if they are interested). I recently requested, under the Access to Information Act, the following document: *Survey of Public Health Capacity in Canada — Report to the Federal, Provincial and Territorial Deputy Ministers of Health by the Advisory Committee on Population Health*, January 2001. My request was refused because the report is "exempt from disclosure." Why has this report, with its interest in the public health of Canadians, not been made public?

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[Editors' note:]

The Minister of Health, Anne McLellan, did not acknowledge our request for a response.

Coronary artery bypass grafting in octogenarians

We read with great interest the article by Kelly Smith and colleagues about coronary artery bypass grafting in octogenarians and septuagenarians.[1] We recently published the results of our experience with coronary artery surgery in octogenarians.[2] Between January 1990 and December 2000, 3282 patients underwent surgical myocardial revascularization at Montpellier University Hospital in France. Forty-two (1.3%) of these patients were 80 years of age or older. Of this group, 13 (31%) underwent valvular replacement with bioprosthesis and 5 (11.9%) died in the first 30 postoperative days. The principal factor associated with decreased survival was valvular replacement. However, long-term results were excellent for patients who underwent isolated coronary surgery; the probability of survival was greater than 85% at 5 years.

In a preliminary retrospective study at the Montreal Heart Institute, we compared the results of coronary artery bypass grafting surgery with and without cardiopulmonary bypass ("on-pump" and "off-pump") in patients over 80 years of age.[3] We found a statistically significant difference in early mortality: about 20% of patients in the on-pump group died in the first 30 postoperative days, compared with 6% of patients in the off-pump group.

In octogenarians without serious comorbidities, age should not be a contraindication for surgical myocardial revascularization. Moreover, off-pump coronary artery bypass surgical techniques may reduce the early mortality rate for octogenarians. A prospective randomized study is warranted to confirm this hypothesis.

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[The authors respond:]

We thank Roland Demaria and colleagues for their interest in our article on coronary artery bypass graft (CABG) surgery in octogenarians and septuagenarians.[1] It is encouraging that similar results in octogenarians are being reported in other provinces and surgical institutions. Our results suggest that CABG surgery in octogenarians (without concomitant valve replacement) is as safe as, and no more costly than, CABG in the younger septuagenarian group, when octogenarians are appropriately triaged. As suggested by Ghali and Graham,[2] an open discussion and debate on the ethical and societal implications of adopting a policy of aggressive revascularization treatment in elderly patients needs be undertaken. First, however, further investigation on the nonmedical outcomes of CABG surgery, such as health-related quality of life, self-efficacy and the impact on independent living, needs to be conducted to bring to this debate a full awareness of the risks and benefits of CABG surgery in elderly patients.

Demaria and colleagues also bring up an interesting point with respect to CABG surgery without the use of cardiopulmonary bypass ("off-pump"). This particular topic was recently discussed in Oct. 2001 at the first meeting of the Canadian Registry for Off-Pump CABG Surgery. This was a Canadian Institutes of Health Research University/Industry funded project, bringing together surgeons from across Canada to develop a data set from which future research will emerge. Results from our

first year of data collection will be presented at the Canadian Cardiovascular Congress in October.

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Telehealth revisted

Regarding the recent discourse in *CMAJ* on telehealth,[1] recognizing that the ability to access information by phone is important to patients, I rarely find that what they describe fits with the model we use to make diagnoses and determine treatment. It would be useful to study the accuracy of this method of treatment. One of my most significant moments in practice was in attempting to make a diagnosis over the phone. In this case, I would easily have missed the diagnosis if I did not have so little faith in telephone consultation.

I had finished my first year of practice. At the end of a morning clinic I received a request for what type of lozenges would be best for a sore throat. This request came to me on a piece of paper with the caller waiting. The person calling had never been seen at our clinic nor had her son for whom she was calling. We had no medical information and she was more than 15 miles away. I spoke with her directly, as was my habit in all such instances.

She stated that her toddler had a sore throat. My response was based on rarely being able to get toddlers to say anything about their symptoms. How did she know it was sore? Her response was "It's obvious from his drooling." With much effort and encouragement I was able to talk the mother into bringing in the child and able to make the diagnoses of epiglottis. He required intubation shortly after.

How can we expect a telephone response system bombarded with upper respiratory calls to separate out such isolated cases? What protocol can help a mother who does not think her child is significantly ill?

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Disordered eating behaviours

Jones and colleagues reported an alarmingly high prevalence of disordered eating behaviours in a community sample of adolescent girls.[1] This study is a valuable addition to the research literature on adolescent dieting. However, the language they used in describing their findings may be easily misinterpreted.

On the basis of the percentage of girls surveyed who scored above a cut-off score on the Eating Attitudes Test-26 (EAT-26),[2] the authors stated that disordered eating attitudes and behaviours were present in over 27% of girls aged 12–18 years. Although the results provide information about the percentage of teenaged girls who show unhealthy dieting behaviours and are at increased risk of developing eating disorders, they do not provide information about the prevalence of disordered eating.

The authors of a recent review, one of whom was one of the authors of the EAT-26, concluded that the predictive validity of this instrument is poor because the prevalence of eating disorders is low (1 to 3%).[3] They recommended that the instrument not be used to establish the prevalence of disordered eating behaviours unless it serves as the first part of a 2-part diagnostic screen and the second part involves a clinical interview with high scorers.

I do not want to minimize the importance of the findings of Jones and colleagues, but they could have facilitated a more accurate interpretation of the results had they noted that the majority of girls who scored above the cut-off score of 19 on the EAT-26 may not actually have a disorder. The percentage of survey participants who score above the cut-off on a self-report screen cannot be equated with the prevalence estimate of a psychiatric disorder.

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[Three of the authors respond:]

We appreciate Frank Elgar's recent letter to the editor drawing attention to our study of disor-