

because of elevated mercury levels thought to be due to environmental or workplace exposure, those levels were instead due to dietary intake.⁵ Health Canada, in May 2001, recommended that such fish be consumed not more than once per week.⁶

Environmentally acceptable levels of mercury are based on what would be unlikely to cause health effects even in high-risk situations such as pregnancy. Nonetheless, in this era of cholesterol anxiety, many health professionals encourage seafood consumption. Physicians need be aware that toxic mercury levels can result when exposure occurs at higher than recommended levels.

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References

1. Casetta I, Invernizzi M, Granieri E. Multiple sclerosis and dental amalgams: case-control study in Ferrara, Italy. *Neuroepidemiology* 2001;20(2):134-7.
2. McGrother CW, Dugmore C, Phillips MJ, Rayond NT, Garrick P, Baird WO. Multiple sclerosis, dental caries and fillings: a case-control study. *Br Dent J* 1999;187(25):261-4.
3. Bangsi D, Ghadirian P, Ducic S, Morisset R, Ciccioppo S, McMullen E, et al. Dental amalgam and multiple sclerosis: a case-control study in Montreal, Canada. *Int J Epidemiol* 1998;27(4):667-71.
4. Rennie AC, McGregor-Schuerman M, Dale IM, Robinson C, McWilliam R. Mercury poisoning after spillage at home from a sphygmomanometer on loan from hospital. *BMJ* 1999;319:366-7.
5. Kales SN, Goldman RH. Mercury exposure: current concepts, controversies, and a clinic's experience. *J Occup Environ Med* 2002;44(2):143-54.
6. Health Canada. *Advisory: Information on Mercury Levels in Fish*. 2001 May 29. Available: www.hc-sc.gc.ca/english/protection/warnings/2001/2001_60e.htm

Cesarean trends

In commenting on the study by Eason and colleagues¹ Scott Farrell appears to have inferred from their findings that there is support for elective cesarean birth as a way of reducing the risk of anal incontinence after vaginal delivery.² We disagree with his interpretation. Furthermore, from a public-health perspective this line of argument is alarming.

Eason and coworkers showed a cumulative incidence of fecal (3.1%) and flatal (25.5%) incontinence. However, these figures include the category "less than once weekly" — a category of du-

bious clinical significance and, likely, one associated with little disruption to quality of life.

Nonetheless, we agree with Farrell that obstetricians and mothers should take an explicit risk-benefit approach when discussing the option of cesarean delivery. We recently studied 8327 consecutive births by women resident in Hong Kong. We found that cesarean section compared to normal vaginal delivery was a risk factor for not initiating breast-feeding (adjusted odds ratio [OR] 1.52, 95% confidence interval [CI] 1.34–1.73) and for breast-feeding less than 1 month (OR 1.25, 95% CI 1.00–1.56), and remained a significant hazard against total breast-feeding duration (hazards ratio [HR] 1.16, 95% CI 1.04–1.30).³ Although it is generally recognized that most mothers recover from birth-related pelvic injury within months of giving birth, the adverse health and developmental effects for infants due to low breast-feeding rates persist well into childhood and adolescence.⁴

The global epidemic of cesarean section is a matter deserving international attention. For instance, Hong Kong's caesarean section rate rose rapidly from 22% in 1993 to 27.4% in 1999, benchmarked against the WHO's recommended upper limit of 15%.⁵ We must not allow the upward trend to continue, certainly not based on inappropriate extrapolation and interpretation of data collected for another purpose.

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References

1. Farrell SA. Cesarean section versus forceps-assisted vaginal birth: It's time to include pelvic injury in the risk-benefit equation. *CMAJ* 2002; 166(3):337-8.
2. Eason E, Labrecque M, Marcoux, Mondor M. Anal incontinence after childbirth. *CMAJ* 2002; 166(3):326-30.
3. Leung GM, Lam TH, Ho LM. Breast-feeding

and its relation to smoking and mode of delivery. *Obstet Gynecol* 2002;99:785-94.

4. Cunningham AS, Jelliffe DB, Jelliffe EF. Breast-feeding and health in the 1980s: a global epidemiologic review. *J Pediatr* 1991;118:659-66.
5. Leung GM, Lam TH, Thach TQ, Wan S, Ho LM. Rates of cesarean births in Hong Kong: 1987-1999. *Birth* 2001;28:166-72.

[The author responds:]

Leung and colleagues raise 3 issues: 1) that my conclusions concerning the protective effect of cesarean section for anal incontinence were based upon the article by Eason and colleagues,¹ 2) that concerns about the detrimental effect of cesarean birth on breast-feeding rates should carry greater weight with women than concerns about pelvic floor injury associated with vaginal birth, particularly assisted vaginal birth, and 3) a global epidemic of cesarean delivery currently exists and must be curbed.

In fact, Eason and colleagues' study did *not* find that cesarean section afforded any protective effect from anal incontinence. I took issue with this conclusion based on evidence from our own prospective study as well as from the work of other authors.² In a study involving 690 women, we found that forceps delivery was associated with a higher incidence of both flatal (RR 2.6) and fecal (RR 3.6) incontinence when compared to cesarean delivery. On the other hand, elective cesarean delivery appears to protect the anal continence mechanism by preserving muscle strength as well as anal sphincter size.³ Although occasional flatal incontinence is unlikely to have a significant impact on quality of life, fecal incontinence has serious sequella.⁴

Faced with a choice between a trial of forceps and cesarean delivery, women must weigh the risks and benefits of these alternatives. Modern cesarean delivery in controlled circumstances is a very safe procedure for both the mother and the fetus. Forceps delivery, on the other hand, while associated with a low risk of fetal trauma, has a significant maternal risk of both short- and long-term sequelae from pelvic trauma. Faced with the choice between cesarean and forceps delivery, would a woman consider a 16% in-

creased risk of not breast-feeding associated with cesarean delivery to be more important than the absolute risks of 44% for flatal incontinence and 9% for fecal incontinence associated with forceps delivery? In a survey of British obstetricians, up to 31% opted for cesarean delivery when faced with a normal full-term pregnancy.⁵ Their reason for choosing cesarean delivery was fear of pelvic injury associated with vaginal delivery. Like these obstetricians, I suspect most women who were properly informed about the risks they face with forceps delivery would prefer cesarean delivery, despite the slight chance that it might influence their chances of breast-feeding.

Leung and colleagues cite the WHO's recommendation that accoucheurs should aim for an upper limit of 15% for cesarean delivery rates as an appropriate benchmark against which we should measure our own rates. The WHO rate, unfortunately, was chosen arbitrarily and was not based on science. Over the last 2 centuries, cesarean section has evolved from an operation performed after the mother died in an effort to save the infant, to an operation that often offers the best option to protect both the mother and the fetus. In many African countries, prolonged obstructed labour results in high rates of maternal mortality. For those women who survive, many experience the particularly morbid complication of vesicovaginal fistula. Access to good obstetric care and timely cesarean delivery could significantly reduce maternal mortality and morbidity in these countries. At a time when maternal and fetal mortality rates are the lowest in recorded history in the developed world (where cesarean delivery rates are higher), one should be cautious about equating cesarean section with the term epidemic, a term that carries significant negative connotations.

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References

1. Eason E, Labrecque M, Marcoux S, Mondor M. Anal incontinence after childbirth. *CMAJ* 2002; 166(3):326-30.
2. Farrell SA, Allen VM, Baskett TF. Anal incontinence in primiparas. *J Soc Obstet Gynaecol Can* 2001;23:321-6.
3. Sultan AH, Kamm MA, Hudson CN, Bartrum CI. Effect of pregnancy on and sphincter morphology and anal sphincter function. *Int J Colorectal Dis* 1993;8:206-9.
4. Donnelly V, Fynes M, Campbell D, Johnson H, O'Connell PR, O'Herlihy C. Obstetric events leading to anal sphincter damage. *Obstet Gynecol* 1998;92:955-61.
5. Al-Muffi R, McCarthy A, Fish NM. Survey of obstetricians; personal preference and discretionary practice. *Eur J Obstet Gynecol Reprod Biol* 1997;73:1-4.

La reconstruction de l'Afghanistan

Dans votre éditorial du 5 février¹, vous avancez que le moment semble venu de se lancer dans la reconstruction de l'Afghanistan et de son système de santé. Il est effectivement temps, car qui se souciait de ce pays? N'oublions pas que l'aide totale apportée à l'Afghanistan a été en chute constante entre 1996 et 2000, passant de 7,9 dollars US à 5,5 dollars US par habitant². Le Canada a adopté une politique moins draconienne, puisque par rapport à 1994, année où les pays de l'Organisation de coopération et de développement économiques (OCDE) ont consenti le plus d'argent, il a conservé un niveau d'aide relativement stable jusqu'en 1999 (7,5 millions de dollars US par an)³. Cependant, si le Canada, comme vous le rappelez, reste un piètre pays au niveau mondial pour l'aide au développement (17e sur 22 pays de l'OCDE⁴), il nous semble qu'il doit non seulement déployer plus d'argent, mais surtout exporter les valeurs sur lesquelles repose (encore) son système de santé. La reconstruction de l'Afghanistan requiert, selon certains⁵, l'organisation d'un fonds commun alimenté par tous les bailleurs. Or, à la lumière de notre propre expérience en Afghanistan ou au Timor oriental, nous avançons que cette solution comporte le risque que la nature du système de santé proposé tende plus vers l'idéologie actuellement dominante de la privatisation et du paiement direct de la part des usagers que vers l'accès universel aux

soins, et nous en connaissons les écueils. Cela revient plus cher à la société et les plus pauvres sont exclus de l'accès aux soins. Le Canada, par l'intermédiaire de son aide internationale, doit promouvoir et appuyer des solutions en lien avec ses propres valeurs. Dans ce cas, il doit soutenir la réorganisation du système de santé fondé sur un financement public qui demeure encore le seul moyen efficace et efficient pour offrir un accès universel et équitable aux soins de santé.

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Références

1. Remettre l'Afghanistan sur pied. *JAMC* 2002;166 (3):295.
2. Banque mondiale. World Development Indicators 2001. Disponible à l'adresse : www.worldbank.org/data/wdi2001/index.htm (consulté le 18 décembre 2001).
3. OCDE. Banque de données SOURCE - CAD. Paris; 2001.
4. OCDE. Table 1: Net official development assistance flows in 2000. Disponible à l'adresse : www.oecd.org/pdf/M00005000/M00005137.pdf (consulté le 2 avril 2002).
5. Wolfensohn, JD. Launching the reconstruction of Afghanistan: official text of remarks delivered at the working session at the US State Department; 2001 Nov 20: World Bank; 2001.

Reference drug pricing

In his commentary, Aslam Anis correctly points out that there is a greater need for randomized trials to assess the therapeutic equivalence of prescription drugs within a class.¹ However, he misinterpreted our results² when he stated that the reference drug pricing policy led to a "10% decline in the use of antihypertensives." Due to a temporary reduction in the length of supply of pharmacy dispensings during a 5-month transition period, the non-significant ($p = 0.15$) dip in dispensings per month is likely to be inconsistent with an underutilization of antihypertensives.³ In Figure 2 of our article it becomes even more obvious that there is no change after the transition period ($p = 0.40$).² Furthermore, we found no increase in the rate of discontinuing antihyperten-