Association and the American Academy of Allergy) owe Canadian holistic physicians an apology for Herbert's appearance in Toronto. Let's hope that *CMAJ* dispenses with Herbert dogma in future issues and provides more balanced coverage of "scientific" conferences.

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Nutrition promoters are painting regular medical colleagues as ignorant, out-of-date puppets of the drug companies and conditioning the public to the concepts of "vegetable good, meat bad" and "natural good, medical bad".

I have always found it difficult to understand the eagerness with which otherwise responsible talk show hosts pander to these hucksters, giving them unopposed air time. I recall one session in which a dean of a naturopathic school was asked in the inevitable phone-in portion how he would treat peptic ulcer. He said he would "get that mucus out of there". Later he waxed philosophical on the meaning of the word "diagnosis", which he said was derived from "di", meaning two, and "agnos" meaning ignorant, so that "diagnosis" meant that two people were ignorant!

Speaking of naturopaths, who now abound, is it not peculiar that a primary contact group with full laboratory privileges sees no ethical conflict in retailing food supplements to their patients? Equally, how can provincial governments permit such practices? I have known patients who spend up to $140 per month for supposedly necessary and superior products, such as rose hips instead of ascorbic acid.

It seems that there is a willing customer for everything that is dished out in the health care field, and this characteristic crosses all societal groups. As surely as motherhood and apple pie, people seem strongly attracted to promises to "rid the body of poisons" or "build up the tissue resistance". More "quackbusters" like Dr. Herbert are needed. We can never outsmart the quack, but we are not doing enough to spread educational material.

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"Farm scene"

The farm scene featured on the cover of the Apr. 1, 1989, issue of *CMAJ* evoked some memories for me, especially since the date was my 70th birthday. As a youth I spent many hours in the metal seat of the side rake behind the team on my uncle's farm.

I questioned the date of the photograph, 1974, as I wouldn't have thought that any southern Ontario farm would harvest hay by that method. Then I thought that the farm might be in the Mennonite or Amish area near Waterloo or Perth county, as the horses appear to be in good health, and the side rake, although an antique, is obviously operational. The odds are about even that it was either a Massey-Harris or a McCormack-Deering. Against the farm's belonging to someone of either sect is that the barn or drive shed is not up to their standard (the roof sags). Also, the harness on the horses is not first rate, and there is a blue, not black, pick-up truck. In favour, there are no utility wires visible, but I believe I can see a pole in the background. Inventions of the devil! The apple tree could stand some pruning. The hay crop is no better than adequate.

One might suspect that this farm is the domain of a matriarch. Note the disparity between the quality of the house and the outbuildings, a sure indicator of who is boss. That situation does not exist in the Mennonite community.

Certainly the scene is quite appropriate for the cover of a Canadian journal as it represents a reasonably typical aspect of our national heritage — family farming.

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[The photographer responds:]

The photograph was indeed taken in 1974 and shows a Mennonite farm along the highway leading north from St. Jacobs, near Kitchener.

As a Mennonite I can assure Dr. Quinlan that there are all varieties of Mennonites. To be certain, one would not expect those farming with horses to have a truck, let alone a blue one. It may have belonged to a visiting "fallen" relative. As to the repair of the buildings and the condition of the trees, I am afraid that not all Mennonites live up to Quinlan's high view of how they look after their property.

Matriarchy may not be the typical Mennonite family structure, but there are always exceptions, as when a widow is left to run a farm or when there are no male heirs and the daughters keep up the farm, usually with some hired help, who quite naturally might not keep a place in as good repair as if they owned it.

I thank Quinlan for his interest in the picture and send him a belated birthday greeting.

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Mixed falciparum and vivax malaria in Canadian travellers

Most patients with malaria are infected with only one *Plasmodium* species. Between July 1987 and July 1988 we treated 33 patients with falciparum malaria; *P. vivax* malaria subsequently developed in 3 in the absence of further exposure to malaria.

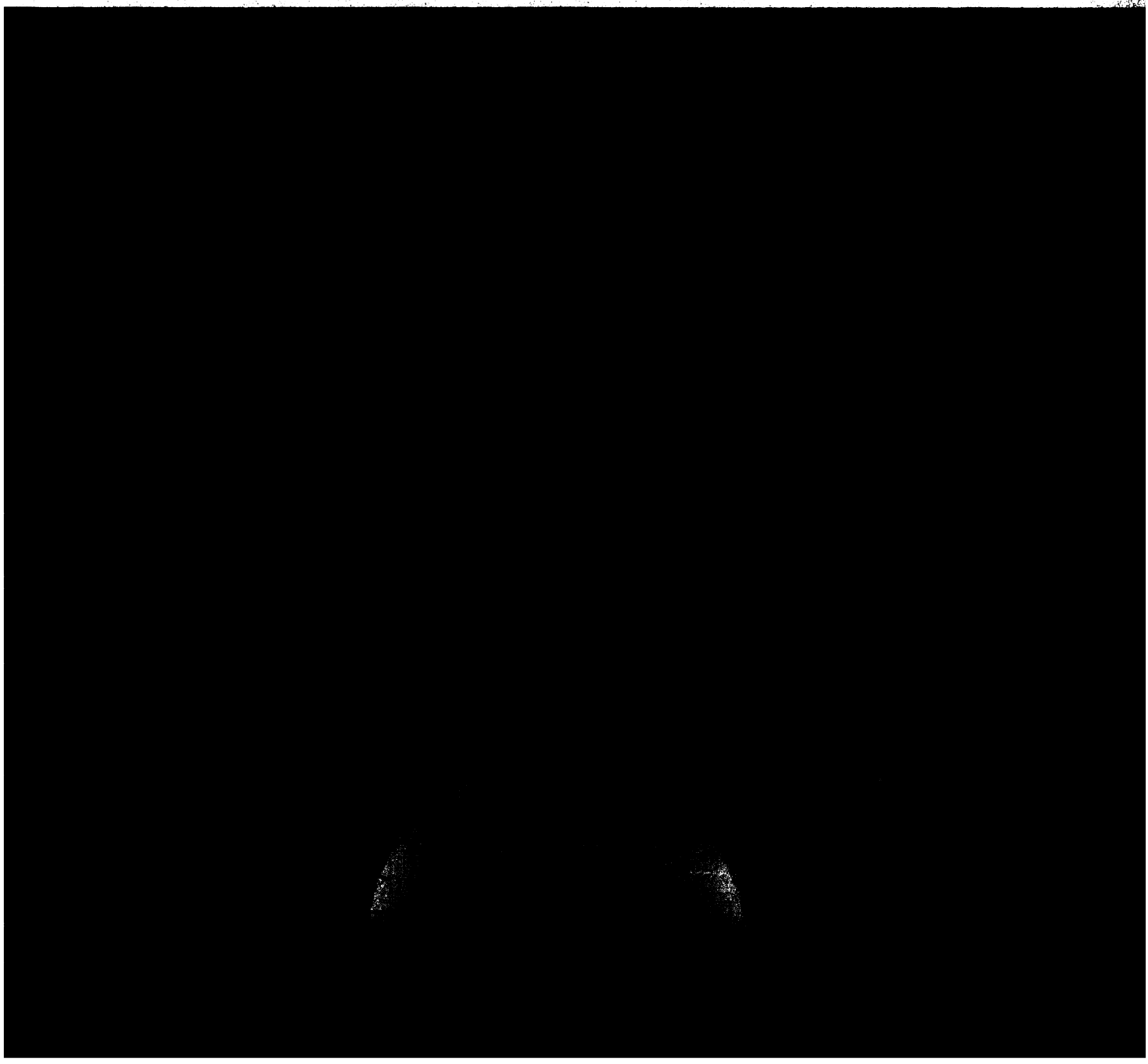
The three Canadian patients had travelled to India, Thailand

and East Africa with chloroquine prophylaxis. The travellers to India and Thailand presented with falciparum malaria within 2 weeks of their return home; the traveller to East Africa had been hospitalized in Nairobi with cerebral malaria and during convalescence was transferred to Canada directly from the Nairobi hospital. All were treated appropriately with quinine and tetracycline or pyrimethamine–sulfadoxine (Fansidar) for chloroquine-resistant *P. falciparum* malaria. None received primaquine prophylaxis against vivax malaria after their travels. Without further exposure to malaria they presented with *P. vivax* malaria 7, 5 and 2 months respectively after their illnesses due to *P. falciparum*.

Mixed infection with *P. falciparum* and *P. vivax* was thought to be very uncommon[1] until Looareesuwan and colleagues[2] reported a 33% rate of relapse with vivax malaria after treatment for falciparum malaria in Thailand. Our three patients represented 9% of those with falciparum malaria treated in our unit in a 1-year period; this proportion may be an underestimate, however, as other patients could have been treated for relapse with vivax malaria at other centres.

Although the intrinsic incubation periods for the two types of malaria are similar (11 to 14 days), *P. falciparum* has suppressed the appearance of *P. vivax* in experiments in which the two parasites were inoculated simultaneously.[3,4] In addition, treatment of falciparum malaria has delayed the appearance of *P. vivax* in the circulation.[5] However, the most likely explanation for the late appearance of vivax malaria in our patients was suppression of the primary febrile illness by chloroquine prophylaxis, with subsequent release of hypnozoites from the liver.

These cases raise the ques-



tion whether all patients with falciparum malaria who have travelled in vivax-endemic areas should not also receive a course of primaquine prophylaxis. The cases should also remind physicians to consider vivax malaria as a cause of febrile illness in a traveller who has been out of the tropics for up to 3 years.

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Recognizing your limitations

I compliment Dr. Eileen Murray for her very sensitive remarks concerning the ethics of commenting on other physicians' treatments (*Can Med Assoc J* 1989; 140: 1131–1132).

I have always felt that it is so easy to inadvertently induce in a patient's mind the idea that another physician's treatment is less than optimal and so create unnecessarily a potential lawsuit scenario. I am sure that we all have come across situations in which treatment received from another physician, as related by the patient, seems to be not what we would prescribe, but I try very hard to ensure that my comments are not construed as open criticism of the other physician, and I hope that other doctors would treat me likewise.

We must realize that medicine is seldom the practice of "black and white" but is many shades of grey. If we feel that a treatment may be obsolete, superseded or outdated, surely our professional and ethical responsibility is to contact the physician concerned and discuss it with him or her directly.

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Premenstrual syndrome

The current popularity of self-diagnoses — premenstrual syndrome (PMS) and "chronic fatigue syndrome" — reflects a conspiracy against reality in today's narcissistic and hedonistic society.

A recent article in the *International Drug Therapy Newsletter*[1] indicates that alprazolam, which appears to ameliorate the symptoms of PMS,[2,3] is the only benzodiazepine that has a distinct antidepressant effect in addition to its anxiolytic and sedative effects. This finding may lend support to my clinical impression that many women who do not meet the diagnostic criteria for premenstrual syndrome may have primary depression with accompanying anxiety.

It is important to diagnose psychiatric conditions by their own criteria and not merely by the exclusion of medical conditions.

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Guidelines for the use of intravenous thrombolytic agents in acute myocardial infarction [correction]

In this article (*Can Med Assoc J* 1989; 140: 1289–1299), by Drs. C. David Naylor and Paul W. Armstrong for the Ontario Medical Association Consensus Group on Thrombolytic Therapy, the first sentence in the "Comments" section on page 1296 should have read as follows: "In summary, the key advantages of tPA appear to be higher recanalization rates . . . and a reduced risk of allergic side effects, which are, however, likely to lead to anaphylactic shock in no more than 1 of every 1000 [rather than 100] people treated with streptokinase . . .". — Ed.

Management of acute asthma [correction]

In this letter (*Can Med Assoc J* 1989; 140: 1127–1128), from Drs. J. Mark Fitzgerald and Frederick E. Hargreave, the second-last sentence should have begun as follows (added information is in italics): "A prospective evaluation of outcome of our emergency department management of asthma *(unpublished data), described in a recent review article,*[5] showed . . .". The results of the prospective evaluation have been submitted for publication. — Ed.