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## Costs and benefits of screening pregnant women for HIV

The recent editorial "The XI International Conference on AIDS: at the crossroads of hope and urgency" (*Can Med Assoc J* 1996; 155:53-4), by Dr. Martin T. Schechter, reinforces the need to reduce vertical transmission of HIV. The implementation of Protocol 076<sup>1</sup> must be the standard of care. The administration of zidovudine during pregnancy and delivery and after birth reduces vertical transmission by 66%, a great advance. The chief medical officer of health, recognizing the need to identify pregnant women with HIV infection early, recommends mandatory voluntary testing.

Does this approach to HIV and pregnancy save money as well as lives? Given roughly 400 000 deliveries in Canada every year, my calculations are as follows. Costs of screening are \$5 for each HIV test (Dr. A.H. Chagla, director, Regional Laboratory, London Public Health Unit, London, Ont.: personal communication, 1995) and \$2200 per mother-infant pair for zi-

dovudine therapy (assuming a 70-kg woman, a 4-kg newborn, 11 hours of labour and an 11-week antenatal treatment period), according to a sales representative from Glaxo. There is a 17% absolute reduction in the risk of vertical transmission if Protocol 076 is followed. The lifetime medical costs of treating an infant with HIV are \$280 000, assuming a cost of \$35 000 per year for 8 years.<sup>2</sup> If 1 in 9000 pregnant women were HIV-positive, the cost of testing for HIV and treating those with the infection would be offset by the savings in reduced medical care costs. My calculation assumes that all pregnant women would consent to testing and comply with therapy, and that all pregnancies would result in a live birth. In Ontario, from 1989 to 1992, an estimated 1 in 4545 women who gave birth to a live infant (1 in 3333 in Toronto and 1 in 2500 in Ottawa) had an HIV infection.<sup>3</sup> This simple exercise shows that we cannot afford to omit voluntary HIV testing from standard obstetric care. What are we waiting for?

Hartmut Bueckert, MD  
London, Ont.

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## Ban relative results? Absolutely!

I welcomed the article "Prevention. How much harm? How much benefit? 1. Influence of reporting methods on perception of benefits" (*Can Med Assoc J* 1996;154:1493-9), by Dr. Kenneth G. Marshall, but found that the article "The perils of prevention" (*Can Med Assoc J* 1996;154:1463), by Dr. Patricia Huston, published in the same issue, failed to recognize the role that medical journals play in overstating the effect of interventions.

If the associate editor-in-chief recognizes the problem of reporting

results in relative rather than absolute terms, it is surprising that she does not propose the logical solution: that medical journals present all study results that show increased or decreased effect in absolute terms. Physicians often struggle with the "clinical significance" of a result, which requires knowing not only the magnitude of effect but also the danger inherent in a disease and its prevalence.

Prevalence is omitted from the data presented in relative terms. It is easy to determine that something that changes a likelihood from 6 in 10 to 3 in 10 is more important than something that changes a likelihood from 6 in 1 million to 3 in 1 million, yet both represent a 50% relative change. If clinical significance is thought of as a fraction, relative numbers provide the numerator and leave out the denominator, giving the clinician no perspective of their importance at the population level.

I therefore suggest that *CMAJ* present all study results in absolute terms only, allowing relative terms in parentheses for a transition period of 1 year. I expect that such a policy will be vigorously opposed by your main advertisers, the drug companies, who have enjoyed success in using relative data to magnify the significance of their products' effect. Nevertheless, having acknowledged the existence of the problem, *CMAJ* and other medical journals have a responsibility to address it.

**Mark Dermer, MD, CCFP**

Assistant professor  
University of Ottawa  
Ottawa, Ont.

**[Dr. Huston replies:]**

**D**r. Dermer has come to the logical conclusion that *CMAJ* should disallow the reporting of results in relative terms, even at the risk of incurring the ire of the drug companies that advertise in our pages. We have been discouraging such reporting for some time, al-

though an occasional article that uses relative reporting may have slipped through. We have not found that this has had any untoward effect on advertising, however, and do not expect that it will.

**Patricia Huston, MD, MPH**

Associate editor-in-chief

## How prevalent is chlamydial infection?

**W**e read with interest the article "Periodic Health Examination, 1996 update: 2. Screening for chlamydial infections" (*Can Med Assoc J* 1996;154:1631-44), by Dr. H. Dele Davies and colleagues. Although we agree with the recommendations, we question some of the assumptions that support them.

The authors ignore the marked decrease in the incidence of genital chlamydial infections in Canada since 1990. The total number of cases in Canada dropped from 50 384 in 1990 to 19 072 in 1995. Similarly, the incidence rate fell drastically during the same period, from 216 to 80 per 100 000.<sup>1-3</sup> Statistics on chlamydial infection first became available in 1990, when the infection became a reportable disease. Although the true prevalence is unknown, it is likely well below the estimate of 7% reported by Massé and associates in 1991.<sup>4</sup>

In our family medicine centre in 1995, samples were obtained from 234 women to be tested for chlamydial infection. Only four positive results were identified. From these data, we estimate the prevalence of chlamydial infection to be less than 3% in our population.

This encouraging drop in incidence may be due to changes in sexual practices, increased use of condoms, the new status of chlamydial infection as a reportable disease, or a combination of these factors. The lower incidence makes screening of the general population even less

cost-effective, but high-risk groups can still be expected to have a high prevalence and should still be screened.

**Donald Sproule, MD, CM, CCFP**

Assistant professor  
**Sanjeev Goel, MD**  
Resident  
Department of Family Medicine  
St. Mary's Hospital  
McGill University  
Montreal, Que.

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### [Two of the authors respond:]

**W**e thank Drs. Sproule and Goel for drawing attention to a decline in the number of reported cases of genital chlamydial infections. We are pleased to see that they agree with and support our recommendations. Unfortunately, there are a number of inaccuracies regarding our assumptions in their letter. We did not ignore "a marked decrease" in the incidence of genital chlamydial infections. Drs. Sproule and Goel allude to two published reports,<sup>1,2</sup> both in the *Canada Communicable Disease Report (CCDR)*, to support this statement. One of these reports was published in February 1996, whereas we searched for articles published between Jan. 1, 1983, and Dec. 31, 1995. Their interpretation of the numbers in both of these interim reports is erroneous. The periodic reporting of compiled statistics by *CCDR* depends on passive reporting of cases by physicians and allied health care workers. The true number of cases usually lags behind the reported number. The 19 072 reported cases in 1995 are only those that had been reported at the time of that *CCDR* issue, which are only those for the first three quarters of