

subcorneal reaction may have remitted spontaneously in a short time, since relapse was not demonstrated.

Case 2 was in a man suffering from chronic lymphocytic leukemia who had an abdominal mass. His liver and spleen were hard and enlarged. The final diagnosis of the mass was not stated. The eruption resolved spontaneously within 3 months of onset.

In both the patients the pustular disorder was not chronic. Associated diseases may have been related to it. As the site of the eruption was not related to the site of exposure to ultrasound, one would have to consider some type of humoral effect if the ultrasonic exposure was the cause. Other forms of radiation have not been associated with subcorneal pustulosis. Although Ingber and colleagues draw attention to acceleration of cellular enzymatic activity there is no evidence that it is in any way different from the minuscule elevation of temperature that must occur when the energy is absorbed.

In summary, it seems highly unlikely that ultrasonography was related to the induction of dermatosis in these patients.

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Death of a profession

I recently received in the mail a letter from the Quebec Medical Association (QMA) accompanying a brochure giving the history of the QMA and its roots in the Canadian Medical Association (CMA) and telling of some articles appearing in

CMAJ on the history of the QMA. The letter, signed by Dr. Gerald Caron, ended by saying that "medicine must be revived".

This was the first official intimation I had had that medicine had expired, and I extend my condolences to all those who believed that it was alive. To some observers it had been poorly for quite some time, suffering from severe ophthalmologic problems along with the lassitude and other symptoms attributable to anemia; to others, medicine itself — official medicine in its various associations and organizations — expired some time ago and was assumed to be alive only through the vigour of its various committees and publications.

That the QMA should now officially admit medicine's demise and urge its members to work on reviving it is interesting. Just how far we should go will depend, I suppose, on the state of the cadaver. If Lazarus was well after 2 days in the grave, who knows what could happen with the QMA?

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Possible origin of human AIDS

Recently Gonda and colleagues¹ reported that the agent of human acquired immune deficiency syndrome (AIDS), human T-lymphotropic retrovirus (HTLV-III), may be closely related to visna virus, an infectious lentivirus of sheep. Visna virus is endemic in some flocks of sheep in Europe, where it is called maedi-visna, and causes a neurodegenerative disease not unlike that seen in the late stages of AIDS in some patients.²

Cases of AIDS have been reported from certain urban areas in northwestern Europe known for their varied and lax sexual mores. One could speculate that a homosexual community in such an area may have become infected by one member's having had sexual contact with a diseased sheep. Once a homosexual community with international connections has become infected, spread of AIDS becomes inevitable.

This is all very speculative, however, and must be substantiated by further epidemiologic and viral studies.

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High prevalence rates of diabetes mellitus and hypertension on a North American Indian reservation

Clinical impressions suggested that the prevalence rates of diabetes mellitus and hypertension were high among the residents of Kahnawake, a North American Indian reservation 19 km from downtown Montreal. The population in 1979 was 5163.

In 1981 we conducted a chart review of 544 people, 92% of the registered Mohawk Indians aged 45 to 64 years on the reservation. Of the 544, 12% were found to be diabetic (having a venous whole-blood glucose level greater than 120 mg/dL [6.7 mmol/L] before meals or greater than 180 mg/dL [10 mmol/L] 2 hours after meals, or already receiving treatment for diabetes¹). Of the 544, 30% also had definite hypertension (having three consecutive chart readings of systolic blood pressure greater than or equal to 160 mm Hg or of diastolic blood pressure greater than or equal to 95 mm Hg, or already receiving treatment for hypertension).

The prevalence rate of diabetes in this population was more than double that reported in a white American population of the same age group and with similar income and education.² The prevalence rate of hypertension was almost double that found in an equivalent white Ameri-

can population.^{3,4} Many North American Indian populations in the United States have very high prevalence rates of diabetes;⁵ for example, 41% of Pima Indians over 35 years of age are diabetic.⁶ There is less information on hypertension; rates based on single blood pressure readings have ranged from 5% to 30%.^{7,8}

In Canada there are no published studies on the prevalence rates of either diabetes mellitus or hypertension in North American Indians. Further research is needed to establish whether high prevalence rates exist in other native populations and, if so, why.

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The balance between research and medical education

I enjoyed reading Burrow's editorial on the need for scholarship in clinical teaching (*Can Med Assoc J* 1985; 132: 514-515). It is hard to dispute the concept of excellence in clinical teaching, but there is a serious flaw in the article. The clinician-teacher is, in fact, much different from academics in other disciplines. The historian or classic scholar is not responsible for large numbers of ill patients; this responsibility robs the clinician-teacher of the vital time needed to write articles and reports. The solution to this dilemma is not simple. Many hours away from direct patient care might easily result in a deterioration of clinical skills, especially if the clinician-teacher is a general practitioner. In any event, under the present economic conditions such action is probably not practical because funds for clinical research are already being stretched.

I do not understand why universities cannot simply accept the fact that the job of a clinician-teacher is to take care of patients and teach medical students and house staff, then give promotions on the basis of excellence in these areas.

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Lung cancer following therapy for Hodgkin's disease

The paper "Lung cancer following therapy for Hodgkin's disease", by Oliphant and McFadden (*Can Med Assoc J* 1985; 132: 533-535), is interesting but, in my view, does not adequately treat what may be the most important issue: the coincidence in a smoker of an extremely common malignant disorder with a less common postulated etiologic antecedent, treated Hodgkin's disease.

The case called to mind a 55-year-old patient who presented with small-cell carcinoma of the lung. She had been a smoker for

many years and had received adjuvant combination chemotherapy for 2 years for stage II breast carcinoma approximately 7 years before the clinical evolution of the bronchogenic carcinoma. Yet the first question she asked regarding possible etiologic factors was about the urea formaldehyde foam insulation in her house.

I am reluctant to see the onus for bronchogenic carcinoma in any way unjustifiably diverted from the arch villain — smoking.

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Vidarabine therapy for herpes zoster

After reading Burdge and colleagues' paper on vidarabine therapy (*Can Med Assoc J* 1985; 132: 392-395) I wish to point out that Vira-A is still an "investigational new drug" for the treatment of herpes zoster.

In our new drug submission to the Department of National Health and Welfare's Health Protection Branch, which is being reviewed, we recommend that, for this indication, a daily dose of 10 mg/kg of Vira-A be given for 5 days. In the patients described by Burdge and colleagues both the daily dose and the duration of therapy were exceeded.

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First-name basis

I wholeheartedly agree with the patient who wrote to express disapproval of physicians' using a patient's first name (*Can Med Assoc J* 1984; 132: 317, 320). It is enough to be sick, without having to be humiliated. In French the use of a person's first name is usually compounded by the use of "tu" instead of "vous", which doubles the insult.

Before our second-year medical students begin visiting patients in our affiliated hospitals I usually re-