

must be based on careful assessment of symptoms, functional impairment and findings in relation to the potential benefits and risks of the procedure. Surgery may indeed be indicated in some patients with minor visual impairment, but our conclusion that “the threshold indications for cataract surgery are now very low” remains valid (and is probably an understatement) on the basis of the evidence we obtained from the best instrument currently available.

Charles J. Wright

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Reference

1. Wright CJ, Chambers GK, Robens-Paradise Y. Evaluation of indications for and outcomes of elective surgery. *CMAJ* 2002;167(5):461-6.

Neuroimaging misinformation

Publicizing the serious risks of traumatic dissection causing vertebral stroke, as Malvinder Parmar did recently,¹ is essential to limit any associated risks, especially those that might result from vigorous chiropractic manipulation. However, the CT image published with Parmar's letter¹ damages the credibility of documented information on this condition. The image shows the suprasellar cisterns and the upper pons, distant from the vertebral arteries. Specifically, the white arrow shows low density, indicating infarction in the right pons, and the black arrow shows the right suprasellar cisterns. The density between the anterior and posterior clinoids is typical for ossification of the dura connecting the clinoids. Calcification of the internal carotid is less likely. The scan slice does not show the vertebral artery, an editorial mistake as serious as labelling a knee “foot.”

Another error concerns the mention of calcification of the right vertebral artery. Calcification would not cause pontine infarction. Rather, it is an epiphenomenon of atherosclerotic dis-

ease. There is also no specific propensity for ipsilateral vertebral dissection to cause ipsilateral pontine stroke. Dissection of either vertebral artery can cause ipsilateral or contralateral infarction. Only infarction of the posterior inferior cerebellar artery is side specific.

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Reference

1. Parmar MS. Telephone stroke [letter]. *CMAJ* 2002;167(10):1104.

[The author responds:]

I thank Allan Fox for his comments and agree that the CT slice published with my earlier letter¹ does not show the calcified right vertebral artery. Rather, it shows calcification in the sellar area. Although the CT image selected for publication did not show the right vertebral artery, the reporting radiologist clearly identified calcification of this vessel in a different slice (Fig. 1). Because of space limitations, only one slice, showing both calcification and the infarct, was selected for publication. Unfortunately, the wrong caption was included with the image, for which I sincerely apologize.

I also agree that the calcium deposit was an epiphenomenon that did not cause the stroke. However, I did not claim that the calcium deposit was the culprit. Rather, I merely speculated that occlusion of the right vertebral vessels caused by abnormal positioning of the neck during a prolonged telephone conversation proba-

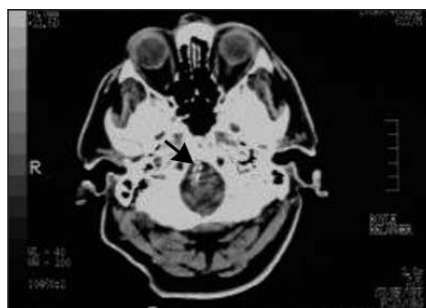


Fig. 1: CT of the head, showing calcification of the right vertebral artery (black arrow).

bly led to thrombosis in the vertebral vessels, which in turn led to embolization of the clot and ultimately the pontine stroke.

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Reference

1. Parmar MS. Telephone stroke [letter]. *CMAJ* 2002;167(10):1104.

Corrections

The following corrections to the *CMAJ* supplement containing the 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada¹ should be noted. In the section on vitamin K (page S19), “menatetrone” should be spelled “menatetrene.” In the third paragraph of the section on parathyroid hormone (page S21), “20 or 40 mg/day injected subcutaneously” should read “20 or 40 µg/day injected subcutaneously.” Summary statement 57a should read “men and women aged 19-50 years ...” (page S23).

Reference

1. Brown JP, Josse RG, for the Scientific Advisory Council of the Osteoporosis Society of Canada. 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada. *CMAJ* 2002;167(10 Suppl):S1-S34.

In a Jan. 21 article on mercury poisoning,¹ an error occurred in the unit of measure. The blood mercury levels indicated in the second paragraph are 176 and 209 µg/L, respectively. The units are listed incorrectly as µmol/L.

Reference

1. Weinstein M, Bernstein S. Pink ladies: mercury poisoning in twin girls. *CMAJ* 2003;168(2):201.

Immunity to Norwalk-like viruses was incorrectly stated to be 14 days in a recent Public Health article.¹ Immunity in fact lasts up to 14 weeks.

Reference

1. Chris A. Norwalk-like viruses: When the runs can slow you down. *CMAJ* 2003;168(1):64-5.