

logical factors, comorbidities and other factors needs to be explored.

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DOI:10.1503/cmaj.1060139

[Two of the authors respond:]

We agree with Herbert Nehrlich that there are many situations in which physicians would benefit from the assistance of health and fitness professionals. It is essential that such advice be sought from professionals who have received formal training and attained national accreditation. In North America¹ these would be professionals certified by the Canadian Society for Exercise Physiology or the American College of Sports Medicine. Together, physicians and health and fitness professionals will be able to provide information that is based on sound physiological principles and a clear knowledge of the absolute and relative contraindications to exercise for a variety of populations.

Giuseppe Lippi and associates correctly point out that vigorous exercise may lead to supplemental health gains in sedentary community-dwelling individuals. There is growing evidence to suggest that certain groups may benefit greatly from high-intensity exercise training. We¹ have advocated high-intensity exercise training for sedentary individuals² and patients with cardiovascular disease³ and chronic heart failure.⁴ However, we are careful to acknowledge that adherence to this form of exercise

may be poor and the risk of musculoskeletal injury higher. Therefore, we must weigh carefully the potential advantages and disadvantages of vigorous exercise for each individual client.

As pointed out by Ediriweera Desapriya and colleagues, discussion of the barriers to exercise and innovative means to deliver inclusive and culturally appropriate physical activity interventions is of great importance. Furthermore, more effective lifestyle interventions are required to address the global crisis of physical inactivity. We have worked diligently to address the barriers to physical activity and have taken a transdisciplinary approach to the creation of novel exercise interventions. More work is required to “develop and deliver” inclusive interventions for all, but we believe that our work^{1,5} is a step in the right direction.

As Rajesh Chauhan and associates point out, the determinants of health are multifactorial and physical activity is not the sole factor influencing health status. However, physical inactivity is an independent predictor of the risk for many chronic diseases and premature mortality. In fact, the risk for chronic disease and premature mortality in North America appears to be about 20% to 50% greater among those with a physically inactive lifestyle.⁵ Furthermore, physical activity appears to be protective in the presence of other known risk factors for chronic disease. Therefore, there is compelling evidence to support the independent health benefits of physical activity.

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DOI:10.1503/cmaj.1060147

Corrections

In a recent review article,¹ a study was mistakenly listed in Appendix 1 as having been excluded from the authors' meta-analysis because of “acute diarrhea not associated with use of antibiotic therapy,” when the true reason for exclusion was that the study in question was not randomized. We regret this error.

REFERENCE

1. Johnston BC, Supina AL, Vohra S. Probiotics for pediatric antibiotic-associated diarrhea: a meta-analysis of randomized placebo-controlled trials. *CMAJ* 2006;175(4):377-83.

DOI:10.1503/cmaj.061138

An error occurred in Figure 1 of a recent Analysis article,¹ whereby *D. latum* was expanded as *Dientamoeba latum* instead of *Diphyllobothrium latum*. We apologize for this error.

REFERENCE

1. Lagacé-Wiens PR, VanCaeseele PG, Koschik C. *Dientamoeba fragilis*: an emerging role in intestinal disease. *CMAJ* 2006;175(5):468-9.

DOI:10.1503/cmaj.061139

An author's name was mis-spelled in the online edition of the August 29 issue.¹ The correct spelling is Catherine Agbokou. We regret the error.

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1. Gauthier S, Herrmann N, Ferreri F, Agbokou C. Use of memantine to treat Alzheimer's disease [letter]. *CMAJ* 2006;175(5):501-2.

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