

venous bolus of insulin at the initiation of insulin therapy.

Many children present to emergency departments staffed by physicians who have a wealth of experience in the management of adult patients with diabetic ketoacidosis but who may not be familiar with the different management considerations required for children and adolescents with this condition. We feel it is important to increase awareness of the more conservative fluid management recommended for pediatric patients, in the hope that this may decrease the incidence of cerebral edema and improve outcomes.

Sarah Lawrence

Danièle Pacaud

Heather Dean

Margaret Lawson

Denis Daneman

Pediatric Section

Clinical Practice Guideline Expert

Committee

Canadian Diabetes Association

Toronto, Ont.

References

1. Chiasson JL, Aris-Jilwan N, Bélanger R, Bertrand S, Beauregard H, Ékoé JM, et al. Diagnosis and treatment of diabetic ketoacidosis and the hyperglycemic hyperosmolar state. *CMAJ* 2003;168(7):859-66.
2. Edge J, Hawkins MM, Winter DL, Dunger DB. The risk and outcome of cerebral edema developing during diabetic ketoacidosis. *Arch Dis Child* 2001;85:16-22.
3. Glaser N, Barnett P, McCaslin I, Nelson D, Trainor J, Louie J, et al, for the Pediatric Emergency Collaborative Research Committee of the American Academy of Pediatrics. Risk factors for cerebral edema in children and adolescents with diabetic ketoacidosis. *N Engl J Med* 2002;344:264-9.
4. Duck SC, Wyatt DT. Factors associated with brain herniation in the treatment of diabetic ketoacidosis. *J Pediatr* 1988;113:10-4.
5. Harris GD, Fiordalasi I, Harris WL, Mosovich LL, Finberg L. Minimizing the risk of brain herniation during treatment of diabetic ketoacidemia: a retrospective and prospective study. *J Pediatr* 1990;117:22-31.
6. Rosenbloom AL, Hanas R. Diabetic ketoacidosis (DKA): treatment guidelines. *Clin Pediatr (Phila)* 1996;35:261-6.
7. Carlotti APCP, Bohn D, Halperin ML. Importance of timing of risk factors for cerebral oedema during therapy for diabetic ketoacidosis. *Arch Dis Child* 2003;88:170-3.

[One of the authors responds:]

Sarah Lawrence and colleagues are correct: our paper addresses hyperglycemic decompensation in adults

only. This was clearly stated in the introduction in an early version of the manuscript, but the information was inadvertently omitted from the final, shortened version. However, the target age group is mentioned in the caption for Fig. 2 of our article.

Jean-Louis Chiasson

Head, Research Group on Diabetes

and Metabolic Regulation

Université de Montréal

Montréal, Que.

Reference

1. Chiasson JL, Aris-Jilwan N, Bélanger R, Bertrand S, Beauregard H, Ékoé JM, et al. Diagnosis and treatment of diabetic ketoacidosis and the hyperglycemic hyperosmolar state. *CMAJ* 2003;168(7):859-66.

Opt out, not opt in

According to a document recently published by the US Centers for Disease Control and Prevention,¹ the province of Ontario, which uses an opt-in approach to prenatal screening for HIV infection, had an abysmal testing rate of only 54%. Such a low rate is clearly unacceptable. Critics of the opt-out strategy argue that it eliminates a woman's autonomy and that it is unethical to perform such an important test without true informed consent. However, given that antiretroviral therapy in HIV-positive pregnant women can potentially reduce vertical transmission rates from about 25% to less than 2%, as reported by Sharon Walmsley in her recent commentary,² is there really any argument for continuing to offer testing on an opt-in basis?

Mark H. Yudin

Obstetrics, Gynecology, & Reproductive

Infectious Diseases

St. Michael's Hospital

Toronto, Ont.

References

1. US Centers for Disease Control and Prevention. HIV testing among pregnant women — United States and Canada, 1998-2001. *MMWR Morbid Mortal Wkly Rep* 2002;51:1013-6.
2. Walmsley S. Opt in or opt out: What is optimal for prenatal screening for HIV infection? [editorial]. *CMAJ* 2003;168(6):707-8.

The drivers of self-discharge

Richard Saitz suggests that intravenous drug use, dates of distribution of welfare cheques and other factors may be reasons for patients wanting to be discharged from hospital against doctors' orders.¹

But has Saitz ever been a patient on an acute care surgical ward? I was admitted to hospital for removal of my gallbladder, which led to an 8-day stay because full open surgery and insertion of a Jackson-Pratt drain were required. Besides the abominable food and resultant hunger and acid reflux, the constant noise (beeping IV pumps and ringing telephones) prevented sleep, day or night. The nurses were fantastic but should have been issued roller skates. Around 4 am there was generally a lull and I was able to doze off, only to be awakened by someone pushing the door open to see if I was OK. Getting back to sleep was almost impossible. Add to all this the patient down the hall who was smoking in his room (I am allergic to smoke), and you can understand why I announced on day 8 that if the doctor did not sign my discharge, I intended to discharge myself.

Anne Sutton Brown

Montréal, Que.

Reference

1. Saitz R. Discharges against medical advice: time to address the causes. *CMAJ* 2002;167(6):647-8.

[The author responds:]

Anne Sutton Brown's experience does not invalidate the systematic observations made in methodologically rigorous studies such as that by Anis and associates¹ or in other work that I cited in drawing my conclusions.² Nonetheless, these studies are clearly not representative of all experiences. For example, the experiences of HIV-positive patients in Vancouver may not apply to patients undergoing gallbladder surgery in Montréal, and vice versa.

As I stated in my editorial,² "the most important void in the literature on discharges against medical advice is the

lack of understanding of why Patients need to be interviewed to find out what motivates them to leave." To fill this gap in the literature, data should be collected systematically, from diverse patient samples and in methodologically sound studies. Some — perhaps many — of the patients in those samples will confirm what Brown has reported. In the meantime, I see no reason to wait to act on the data already provided by high-quality research, which suggest that we should address addictions properly in patients who have them.

Richard Saitz

Associate Professor of Medicine and Epidemiology
Boston University Schools of Medicine and Public Health
Boston, Mass.

References

1. Anis AH, Sun H, Guh DP, Palepu A, Schechter MT, O'Shaughnessy MV. Leaving hospital against medical advice among HIV-positive patients. *CMAJ* 2002;167(6):633-7.
2. Saitz R. Discharges against medical advice: time to address the causes. *CMAJ* 2002;167(6):647-8.

A practical case

I'd like to thank *CMAJ* for printing Robert Slinger and Theodore Scholten's article about the boy with a botfly infestation.¹ I experienced a similar history for 11 weeks after my vacation. The correct diagnosis had been missed, and I was booked for removal of a sebaceous cyst. Then my husband, who is also a physician, read the case report and, suspecting that a botfly infestation might be the problem, extracted a 2.4-cm larva from my scalp.

If one of the reasons for printing unusual case studies is to help physicians, then this article certainly filled the bill. I just never suspected that I would be the patient!

Naomi Sato

General Practitioner
Mississauga, Ont.

Reference

1. Slinger R, Scholten T. Facial furuncle on 3-year-old boy camping in Ontario. *CMAJ* 2003;168(9):1159.

National Network of Libraries for Health

In their article on technology-enabled knowledge translation, Kendall Ho and colleagues¹ emphasize physicians' need to "locate and access evidence to support decision-making." Organizing information, particularly electronic information, is exactly what libraries do, and we commend the initiative that Ho and colleagues describe.

The Canadian Health Libraries Association has proposed a National Network of Libraries for Health, which would build on existing resources and ensure universal access to licensed publications available through the Web. The proposal was recognized in the Romanow report² and is supported by Health Canada, the Canada Institute for Scientific and Technical Information, the Association of Canadian Medical Colleges, the US National Library of Medicine and the Canadian Cochrane Network and Centre. However, it has not yet been funded.

Jessie McGowan

Co-Chair

Jim Henderson

Member

Patrick Ellis

Co-Chair

Task Force for the National Network of Libraries for Health

Canadian Health Libraries Association
Toronto, Ont.

References

1. Ho K, Chockalingam A, Best A, Walsh G. Technology-enabled knowledge translation: building a framework for collaboration [editorial]. *CMAJ* 2003;168(6):710-1.
2. Commission on the Future of Health Care in Canada (Romanow R], chair). *Building on values: the future of health care in Canada*. Saskatoon: The Commission; 2002. Available: www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf (accessed 2003 Jun 4).

[One of the authors responds:]

The notion that libraries are integral to evidence-based decision-making for health care professionals is well worth emphasizing. Librarians have tremendous expertise in searching the literature, devising and refining

search strategies, and pinpointing the evidence, activities that usually involve the use of modern information and communication technologies, such as those we described.¹ Physicians and, for that matter, all health care professionals, can benefit from librarians' expertise and from their coaching as they acquire these important skills themselves.

The Division of Continuing Medical Education within the University of British Columbia Faculty of Medicine has been offering workshops to help physicians in using the Internet for evidence-based medicine, and librarians have been members of the workshop faculty since the inception of these courses. Similar approaches are being used across Canada and internationally.² An even more interesting model is the integration of librarians or information specialists into the clinical setting for team-based practice and learning.³

Kendall Ho

Division of Continuing Medical Education
Faculty of Medicine
University of British Columbia
Vancouver, BC

References

1. Ho K, Chockalingam A, Best A, Walsh G. Technology-enabled knowledge translation: building a framework for collaboration [editorial]. *CMAJ* 2003;168(6):710-1.
2. Dorsch JL, Jacobson S, Scherrer CS. Teaching EBM teachers: a team approach. *Med Ref Serv Q* 2003;22(2):107-14.
3. Florance V, Giuse NB, Ketchell DS. Information in context: integrating information specialists into practice settings. *J Med Libr Assoc* 2002;90(1):49-58.

Creating immunity

The argument in a *CMAJ* editorial¹ that "Unless a large proportion (usually over 95%) of the population is vaccinated, herd immunity will not result and outbreaks will recur" had me scratching my head. The same editorial notes that "the near-complete immunization of whole populations in childhood has led, decades later, to whole populations of adults with waning immunity to some childhood diseases," giving as an example pertussis, which