



## Analyzing the risks of cesarean delivery

Shiliang Liu and colleagues conclude that the risks of severe maternal morbidity associated with planned cesarean delivery are higher than those associated with planned vaginal delivery.<sup>1</sup> However, a cross-sectional study of associations is nondirectional and one cannot infer either the presence of causality or its direction.

During the 14-year study period, the rate of cesarean deliveries was increasing and morbidity was probably decreasing. Associations between 2 heterogeneous data sets are not meaningful. One needs data from a recent homogeneous time period to produce statistical associations that are relevant for current practice.

Finally, the authors acknowledge that although the morbidity rate differences were statistically significant, the absolute differences were small. The authors do not state which, if any, of these small differences were clinically significant.

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**Competing interests:** None declared.

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## Treatment of septic arthritis

Raheem Kherani and Kam Shojania recently provided a comprehensive overview of septic arthritis; however, I have some concerns about the antimicrobial therapies outlined in their article.<sup>1</sup> The authors recommend that gram-positive cocci identified in Gram's staining of synovial fluid should be treated with cefazolin if the infection was acquired in the community. This treatment recommendation does not consider the emergence of community-acquired methicillin-resistant *Staphylococcus aureus* in Canada.<sup>2</sup> When one is treating an infection that leads to joint destruction or sepsis, it is prudent to include vancomycin as a first-line agent until the antibiotic susceptibility of the organism is known.<sup>3</sup>

My second concern is the authors' recommendation that cefazolin and gentamicin should be used to treat cases in which Gram's staining does not show bacteria. Most treatment recommendations for this scenario include a third-generation cephalosporin and vancomycin for empiric coverage of the most common bacterial pathogens. *Neisseria gonorrhoeae* would also be covered by this broader regimen; it is a common cause of septic arthritis in patients at risk for sexually transmitted infections. With the rising incidence of gonorrhea in Canada<sup>4</sup> and the frequency of a negative result of Gram's staining with gonococcal arthritis, this organism should at least be considered when treating septic arthritis.

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**Competing interests:** None declared.

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2. Hawkes M, Barton M, Conly J, et al. Community-acquired MRSA: superbug at our doorstep. *CMAJ* 2007;176:54-6.
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### [The authors respond:]

We thank Cheryl Main for her comments on the antimicrobial coverage for both gram-positive and gram-negative septic arthritis that we recommended in our article.<sup>1</sup> Our review focused on non-gonococcal septic arthritis in patients with pre-existing inflammatory arthritis, and space constraints meant that we could not elaborate on many special circumstances.

Unfortunately, the literature on community-acquired gram-positive septic arthritis in this population is limited. One case series of 59 patients with septic arthritis (in which 15 of the cases were due to MRSA and 44 were not) includes several patients with pre-existing rheumatic disease but does not provide details on the nature of their rheumatic disease.<sup>2</sup> The authors of this case series suggest considering empiric treatment for MRSA infection in patients with septic arthritis if there are risk factors such as recent admission to hospital, known infection or colonization with MRSA, multiple comorbidities in addition to the rheumatic disease, injection drug use or residence in communities known to have a high prevalence of community-acquired MRSA infections. These suggestions are consistent with our interpretation of the guidelines referenced by Main.<sup>3,4</sup> Hawkes suggests that people of First Nations or African-American heritage, athletes who participate in contact sports, injection drug users, men who have sex with men, military personnel, inmates of correctional facilities, veterinarians, pet owners and pig farmers may be at increased risk of developing MRSA infections.<sup>3</sup> As a result, our recommendations continue to be to use cefazolin empirically. For patients known to have risk factors for MRSA infections, vancomycin should be included in the

treatment plan until the organism's susceptibility is established.

Although gram-negative infections occur less frequently than gram-positive infections, they are important and potentially difficult to treat. Although it was not the focus of our review, gonococcal septic arthritis should be considered in patients who have demographic risk factors for this condition or in whom Gram's staining does not show bacteria.

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## Health Canada's new standards on conflict of interest

In a *CMAJ* news piece, Wayne Kondro stated that "Canada has no hard rules governing exemptions or waivers. Experts with conflicts are allowed to sit on [scientific advisory] panels without a formal waiver process."<sup>1</sup> This is incorrect. Health Canada has been working and consulting with the public on this issue for some time and recently released standards that define conflict of interest for advisory body members and impose standards that are stricter than those of the US Food and Drug Administration (FDA).

Through the department's new *Review of Regulated Products: Policy on Public Input*,<sup>2</sup> we are providing opportunities for public input when it can strengthen risk-benefit assessments of regulated products. A new guidance document<sup>3</sup> clarifies our practices in managing advice from external experts, including the fact that anyone with a direct financial interest in the outcome of a product review will be barred from participating in an advisory body involved in that review. Unlike the FDA's policy, this is a blanket exclusion, and there are no waivers.

Health Canada places a high value on the expertise that it receives from its advisors, who can be in limited supply. The new policy and the guidance document make clear that only direct financial interest is a bar to participation and that not all affiliations and interests are conflicts. Affiliations may, in some instances, be desirable (e.g., valuable clinical or research experience with a particular drug). Rather than exclusion, our policy supports diversity of perspective, and a range of affiliations and interests in the membership of our advisory bodies, in an effort to obtain comprehensive, credible advice.

Furthermore, the guidance document includes a requirement that background information about advisory body members, including their relevant expertise, experience, affiliations and interests, be made publicly available. Like the FDA, we expect a rigorous, transparent approach to the selection of advisory body members to contribute to public confidence in government decision-making.

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1. Kondro W. US proposes more stringent conflict-of-interest rules. *CMAJ* 2007;176:1571-2.
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#### [CMAJ responds:]

The information in the news article<sup>1</sup> regarding Health Canada's rules governing exemptions and waivers for its panel members came directly from a Health Canada spokesperson, Carole Saindon.

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## Whose responsibility is it?

I agree with much that my old friend Michael Bliss put forward about "socialized medicine and Canada's decline,"<sup>1</sup> but I would submit that the responsibility for our inadequate health care system rests more with our medical educators — the clinicians and the professors — than with our politicians. True, in the pre-medicare days, we did maintain high standards of medical education and we produced competent doctors. However, in 1968, our profession handed over responsibility for policy, planning and human resource development holus-bolus to the politicians, the health economists and the bureaucrats. We did so with scarcely a whimper and subsequently let our new masters in Ottawa confine us in a legislative strait-jacket called the Canada Health Act, with its 5 criteria or pillars: accessibility, universality, comprehensiveness, portability and public administration.

In their zeal to exercise this kind of control, the architects of the Canada Health Act are guilty of an incredible oversight. Nowhere in this statute is there a word about the responsibility for the training and distribution of health care professionals. Furthermore, there is nothing to indicate which level of