REFERENCES

1. Lippman A, Melnychuk R, Shimmin C, et al. Human papillomavirus, vaccines and women's health: questions and cautions. *CMAJ* 2007;177:484-7.
2. Allen HH, Nisker JA, Anderson RJ. Primary surgical treatment in one hundred and ninety-five cases of stage 1B carcinoma of the cervix. *Am J Obstet Gynecol* 1982;143:581-4.
3. Canadian Cancer Society, National Cancer Institute of Canada. *Canadian cancer statistics 2007*. Toronto: National Cancer Institute of Canada; 2007. Available: www.ncic.cancer.ca/vgn/images/portal/cit_86751114/21/40/1835950430cw_2007stats_en.pdf (accessed 24 Oct 2007).
4. Nisker, J. Philip. *CMAJ* 2003;168:746-7.
5. Nisker J. The need for public education: "surveillance and risk reduction strategies" for women at risk for carrying BRCA gene mutations. *J Obstet Gynaecol Can* 2007;29:510-1.
6. Colgrove J. The ethics and politics of compulsory HPV vaccination. *N Engl J Med* 2006;355:2389-91.

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[Three of the authors respond:]

We wrote our commentary[1] hoping to initiate a broader discussion about how limited public resources are allocated, about the kinds of questions and concerns that might be addressed before programs are initiated and about the place of HPV vaccinations in an overall cervical cancer prevention policy that is already having success in Canada through the use of Pap smear testing. We maintain this focus here.

We thank James Mansi for responding for Merck Frosst but note that he does not actually address our concerns directly. We acknowledge the points he has raised; however, even adding the 3 components Mansi includes in the "new standard of care" (proper education, continued Pap smear testing and post-vaccination surveillance) will still leave a vaccination program insufficient. We also need — at the least — much improved cervical cancer screening programs and vaccine registries, as well as better knowledge of the prevalence of HPV strains and of the duration of protection before we consider mass vaccination programs. Moreover, we must determine whether and how vaccinating girls and women (who are already mostly well protected by their own immune systems, safer sex practices and existing screening programs) would actually change the inequitable death rates from cervical cancer in Canada.

That Eduardo Franco and colleagues would consider our cautionary position "irrelevant and untenable" is most puzzling. We are pleased to see that James Brophy, by contrast, finds it "sagacious." The precautionary principle is one that many people apply in assessing public health programs (see www.sehn.org/precaution.html for a discussion of this principle). Furthermore, we clearly stated that HPV was a necessary — but not sufficient — cause of cervical cancer; what, then, is the purpose of Franco and colleagues' example of smoking and lung cancer?

More importantly perhaps, we never questioned the selection of young women aged 15–25 years for participation in studies of the vaccine's efficacy, nor did we question the facts that immune responses in adolescents may be stronger than those in young adults and that vaccination is of maximal benefit when used for pre-exposure prophylaxis. We did ask, however, if 5 years of trials provided enough information to proceed with a mass vaccination program given that the vaccine's effectiveness rates are just starting to be known. (In response to Alex Ferenczy, we point out that our comment about the trials available for review was based on data presented by Lisa Rambout and colleagues:[2] only 3 of the 6 studies meeting their inclusion criteria for systematic review were of the quadrivalent vaccine. This would seem to be a "handful.")

Nevertheless, and notwithstanding the "utmost scientific rigour" of the randomized controlled trials (although Brophy has raised some interesting issues about this), about half of the 50 000 girls and women in the vaccine trials participated in studies of the bivalent HPV vaccine, Cervaris, which we did not discuss in our commentary. As well, the published report of the study by Reisinger and colleagues describes the experiences with Gardasil of only a limited number of girls aged 9–15 years (617 in the vaccinated group, 322 in the control group), which is the main age range for immunization in Canada, and provides data only on immunogenicity and short-term safety, not on efficacy.[3] Thus, conflating all of the girls and women who were studied with this very small group of particular interest is inappropriate.

Alan Cassels repeats, while most others ignore, the basic question our commentary raised for discussion: Why begin mass vaccinations now? Where is the evidence base for this important public health decision? The letter writers who confuse the issue of epidemics with details of the ways in which women with cervical cancer suffer deflect this question. They also perhaps ignore the current gaps in care that may explain why many women ultimately diagnosed with invasive cervical cancer did not have a Pap smear test when it was due despite having received care from physicians in the previous 5 years (Ms. Kathleen Decker, CancerCare Manitoba: personal communication, 2007).

Women, and men, suffer in myriad ways, and public health policies need to focus on where best to allocate finite resources, not only on an individual level but also with regard to population needs. This means that cost-effectiveness and lost opportunity costs are usually taken into account. As Schiffman has pointed out in the US context, "It is worth debating ... whether immediate, universal coverage is a greater public health priority ... than other needs ... competing for the same resources."[4] We need to have this debate in Canada. In addition, with regard to Jeff Nisker's distinction between individual decisions about the use of the vaccine and public policies about a program of vaccinations, we need to emphasize that both personal and population health care must always be based on the primary principle of "do no harm."

Wynia recently wrote that "this vaccine still faces plenty of questions."[5] We hope readers will continue to discuss these questions and the place of HPV vaccination in a broad sexual and reproductive health perspective and to accept alternative viewpoints generously and in reasoned fashion, even ones that question supposedly "established" wisdom.

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Competing interests: None declared.

REFERENCES

1. Lippman A, Melnychuk R, Shimmin C, et al. Human papillomavirus, vaccines and women's health: questions and cautions. *CMAJ* 2007;177:484-7.
2. Rambout L, Hopkins L, Hutton B, et al. Prophylactic vaccination against human papillomavirus infection and disease in women: a systematic review of randomized controlled trials. *CMAJ* 2007;177:469-79.
3. Reisinger KS, Block SL, Lazcano-Ponce E, et al. Safety and persistent immunogenicity of a quadrivalent human papillomavirus types 6, 11, 16, 18 L1 virus-like particle vaccine in preadolescents and adolescents: a randomized controlled trial. *Pediatr Infect Dis J* 2007;26:201-9.
4. Schiffman M. Integration of human papillomavirus vaccination, cytology and human papillomavirus testing. *Cancer* 2007;111:146-53.
5. Wynia MK. Public health, public trust and lobbying. *Am J Bioeth* 2007;7:4-7.

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Advertisement

In a recent issue of *CMAJ* (2007;177:858), there is an advertisement for yet another testosterone product, Testim. This advertisement pictures a scantily clad young woman pressing her breasts against the windshield of a car and suggests the possible reactions of a patient receiving testosterone. Unfortunately, the ad's checklist doesn't include "offended." There is no suitable place for ads that demean women, and the professional journal of the Canadian Medical Association is the worst possible place for such an ad. *CMAJ* policy about advertisements in the journal needs to be brought into the current century, where sexism is no more acceptable than racism.

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Competing interests: None declared.

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I found the advertisement for Testim (*CMAJ* 2007;177:858) with the large-breasted woman pressed against the windshield of a car to be sexist and offensive. I found it hard to believe this ad was published in a magazine of *CMAJ*'s calibre and reputation. This ad looks like something that belongs in *Maxim* magazine, not *CMAJ*. I and the rest of the female physicians who read your journal deserve much better.

Maria Kang MD
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Competing interests: None declared.

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I was disappointed to see an advertisement in the Oct. 9 issue (*CMAJ* 2007;177:858) that explicitly objectifies a woman's body. The multiple choice option below the picture seems to suggest that men who fail to objectify a woman in such a way are suffering from low testosterone. I'm sure you will agree that respect for all genders is not pathologic.

I enjoy reading *CMAJ*, and I understand the necessity of pharmaceutical advertising revenue. However, in future, I hope *CMAJ* will consider the message of advertisements included in the print journal.

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Competing interests: None declared.

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[Paladin Labs Inc. responds:]

I would like to assure *CMAJ* readers that our decision to run the Testim advertisement was carefully considered. The following points were important in our evaluation:

We believe that the Testim Advertisement is appropriate and relevant to the product category. Testim is indicated for testosterone replacement in hypogonadal men. The lack of a sexual response is among the chief complaints of patients with low testosterone. Because patients respond differently to various delivery forms of testosterone replacement, our ad asks physicians to consider whether their patients are achieving an improvement in symptoms with their current medication. Our ad uses an iconic stock image of an attractive woman to pose that question in a way that attracts the attention of the reader. We believe that our advertisement makes good use of this cliché to communicate an important point about the effectiveness of Testim. The fact that this Advertisement is directed solely toward physicians also contributed to our decision. Physicians are an educated audience who are able to understand the message of this Advertisement in its appropriate context of optimizing testosterone therapy.

We did not feel that there was anything inherently degrading or inappropriate in the premise that an attractive woman may provoke sexual interest in a man with a normal testosterone level. This is a goal of therapy. Many patients seek help when declining sexual interest becomes a problem in their lives. When assessing whether a patient is responding to testosterone therapy, physicians will routinely ask their patients whether they have noticed an increase in their libido.

The advertising materials were reviewed by physicians who indicated that they found this approach to be clever, appropriate and reflective of the types of real issues that they face when treating patients with low testosterone. We recognize that advertising, particularly advertising dealing with sexual subject matter, can provoke strong responses. Nonetheless, we have received a great deal of positive feedback on this campaign, both for its appropriateness and for our willingness to break away from "traditional" pharmaceutical advertising.

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Competing interests: Mark Beaudet is an employee and stockholder of Paladin Labs Inc.

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