Response

Thank you. We appreciate your input and the time you took to comment on our Critical Appraisal article. The errors in the table appear to have been typographical; we appreciate that you made note of them. Also, we were incorrect to say that candidates who failed the run-in period were excluded. The study was an intention-to-treat analysis, so all patients were included regardless of compliance. Fortunately, these two errors made little difference to the interpretation of the study.

We have reviewed our description of the methods of the study and find it to be a correct representation of the article. If your knowledge of the methods is related to personal participation in the study, then the article itself is incorrect.

While we appreciate that knowledge in the area of *Helicobacter pylori* continues to evolve, we did not have access to any of the literature you describe that was published after the article we reviewed. Certainly we did not have access to your abstract, which was published months after we submitted our review. Thank you for taking the time to provide us with this new information.

While this new literature does ask us to reconsider some of the subtle nuances of the study, it does not change the "bottom line" of the study we reviewed for family physicians. You interpreted our writing to convey to readers that every dyspeptic patient should be investigated before treatment. The message we meant to convey was that every dyspeptic patient a family physician considers *treating with eradication therapy* be investigated. If an investigated patient has an ulcer (and is *H pylori*—positive), then treat; if not, eradication therapy will probably make little difference to symptoms.

Also, in our review we addressed literature that suggests there might be "good" *H pylori* and that eradicating them would be "bad" because it might be harmful to patients. This literature is not definitive, however, where patients could be harmed when a treatment has been shown not to improve morbidity (in this case *H pylori* eradication in a dyspeptic patient without ulcer). In such cases, it is the usual standard of practice not to offer the treatment. It is probably reasonable not to investigate dyspeptic patients without ulcer for *H pylori* because testing for something inherently leads to treating it, even though treatment might not be beneficial. Thank you for apprising our readers of the connection between *H pylori* and gastric cancer and the rising incidence of distal esophageal adenocarcinoma. Obviously, eradication for cancer prevention is an important topic, and we look forward to increasing evidence that this strategy makes sense in primary care.

Incidence numbers given at the beginning of the article were taken from our first reference.[1] The numbers are different because there is a difference in prevalence between dyspepsia and upper abdominal pain (as stated in the article). As you know, these rates vary somewhat depending on the source and, of course, the clinic setting.

We appreciate your reiteration of our main points and your correction of the data. Your suggestion regarding specialty contributors to the critical appraisal section is interesting and something we have wrestled with. Clearly, you know more about dyspepsia than we do, and this could be an advantage for our readers. This needs to be balanced with the fact that some of the subtle nuances important to you as gastroenterologists are not as important to us as family physicians. As well, given selection bias, prevalence, and so on, the strategies that specialists derive from the literature might differ from strategies derived by family physicians. We are more likely to write critical appraisals that address the diagnostic and therapeutic concerns other family physicians face in their offices each day.

As a result, we think that family physicians are the best primary reviewers. Also, many of the articles we review are not written by specialists. We do think many specialists are becoming more sensitive to the realities of primary care, and we did send this critical appraisal to the primary author of the article we were appraising for feedback before publication. As well, a gastroenterologist with much expertise in the area of *H pylori* and non-ulcer dyspepsia gave us feedback on the review prior to publication. Thank you again for your interest and useful comments on our article.

References

1. Locke GR III. Prevalence, incidence and natural history of dyspepsia and functional dyspepsia. *Baillieres Clin Gastroenterol* 1998;12(3):435-42.

—*Michael Evans*, MD, CCFP
Toronto, Ont
—*Clayton Hammett*, MD
Toronto, Ont

Be careful about drawing conclusions

Our group of family medicine residents at McMaster University in Hamilton, Ont, have the following response to Graham Worrall's article,[1] "One hundred earaches. Family practice series."

In the article, Dr Worrall reviews a family practice case series of 100 earaches. Of the 100 patients assessed, only four received antibiotics: two on the first visit and two in follow-up visits. The author subsequently concludes that "most people who present to primary care physicians with earache do not need antibiotics."

We are concerned about the generality of this claim. This author's work only demonstrates that most patients seen with earache in his clinic did not return to his clinic for earache. It does not show that antibiotics are unnecessary

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for most earaches or that patient outcome is better without antibiotics. As the author mentions, patients might have simply visited other physicians for treatment. In fact, if antibiotics were used initially, a difference might have been observed in the duration of pain, complication rates, and length of illness.

Furthermore, while case series provide snapshots of actual clinical practice and can provide leads for further research, this study design cannot be used as evidence for causation.

The question of whether watchful waiting is an appropriate strategy for patients with earache is an interesting one; however, we should be cautious about drawing conclusions that the results and study design cannot support.

—Rosalind Ward-Smith, MD
—David Palmer, MD
—Paul Colella, MD
—Martha Graham, MD
—Jonel Miklea, MD
—Jennifer Mueller, MD
—Odette Wahba, MD
—Dale Guenter, MD
Evidence-based Medicine Group, Family Medicine Program, McMaster University, Hamilton, Ont
by e-mail

Reference

1. Worrall G. One hundred earaches. Family practice case series. *Can Fam Physician* 2000;46:1081-4.

Response

As a McMaster University epidemiology graduate myself, I cannot disagree with the comments made by my colleagues. We all know that a case series presents weak evidence. The study was meant only to suggest that, in clinical situations where the evidence for an intervention is unclear, a good case can be made for not intervening—in this case, for not prescribing antibiotics.

With regard to the generalizability of my study, I can only advise my colleagues to look at the sex, age, and times of presentation of the 100 patients in the study; I think they will look familiar to most physicians who provide walk-in or out-of-hours services.

My colleagues suggest that patients who were not given antibiotics by me might have soon after attended other physicians for their desired medication; in understaffed rural areas like ours, where there are very few other family doctors, and waiting times to see them extend to days or weeks, this is unlikely to have occurred in more than a few cases.

Good luck to evidence-based medicine!

—Graham Worrall, MB BS, MSC, CCFP, FCFP
Whitbourne, Nfld

Article not doctor-friendly

I have a special examining room designed for babies only, and I considered my office to be "baby-friendly." That is until I read the article[1] in the May issue. I was amazed to find out that, if I do not promote breastfeeding 100% of the time, my office is not baby-friendly.

The title of the article is not doctor-friendly by accusing me of not being baby-friendly if I do not follow the 10 commandments listed in the article. I consider myself baby-friendly even if I do not promote breastfeeding 100% of the time.

—Ilmar J. Kents, MD
Brantford, Ont
by e-mail

Reference

1. Shariff F, Levitt C, Kaczorowski J, Wakefield J, Dawson H, Sheehan D, Sellors J. Workshop to implement the baby-friendly office initiative. Effect on community physicians' offices. *Can Fam Physician* 2000;46:1090-7.

Response

Dr Kents is concerned about possible negative connotations arising from the nomenclature "baby-friendly office" used to describe offices that protect, promote, and support breastfeeding.

It is the terminology that was used by the World Health Organization (WHO) and the United Nations Children's Emergency Fund (UNICEF) when they jointly launched the Baby-Friendly Hospital Initiative. The Baby-Friendly Hospital Initiative is the global initiative arising from the Innocenti Declaration that was produced and adopted at the WHO-UNICEF policy makers' meeting on "Breast feeding in the 1990s: A Global