

ical examinations for immigration applicants are authorized to undertake these services by Citizenship and Immigration Canada and do not work for Health Canada as indicated in the article. For reference, a listing of these physicians can be found at the department's Web site at www.cic.gc.ca/english/info/medical.html.

Second, the guidelines for the management of immigrants and refugees under surveillance for tuberculosis, noted in the article, have been revised since their initial publication in 1993. The latest guidelines in this regard were published in 2001² and are available on Health Canada's Web site at www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmt/c/01vol27/dr2719ea.html.

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1. Weir E. Caring for refugees. *CMAJ* 2002;166(11):1441.
2. Canadian guidelines for the investigation and follow-up of individuals under medical surveillance for tuberculosis after arrival in Canada. *Can Dis Wkly Rep* 2001;27:157-65.

[The author responds:]

I thank Brian Gushulak for his attention to the column and for offering these corrections.

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Moxibustion

I was very surprised to see the article entitled "Unusual skin findings in a patient with liver disease."¹ The title implies that the skin manifestations described are due to liver disease and it also highlights that these findings are unusual.

Moxibustion has been used exten-

sively in the Far East (Southeast Asia, China, India and Japan) for many centuries and for many kinds of diseases, including pleurisy, pneumonia, abdominal pain, chest pain and local pains, and is equivalent to the Western medicine practice of prescribing hot compresses as an anti-irritant to attract white blood cells and antibodies to the irritated area.

The term moxibustion refers to the application of a small amount of a dried plant material (*Artemisia moxa*), but it usually also involves scraping the skin with, traditionally, copper coins to create redness (see the right-hand figure in the *CMAJ* article). Glass cups are also used; these leave much larger marks than the ones shown in the left-hand figure (usually 2-3 cm in diameter). A drop of alcohol is placed in the cup, lit with a match and immediately applied to the painful area. Instantly, the flame goes out as the 20% oxygen is used up; the skin is sucked up into the cup and allowed to stay in place for a few minutes (creating a red area) and then pulled off. This process is sometimes associated with acupuncture.

I lived in China for 16 years and saw innumerable people with these skin manifestations.

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Reference

1. Fisman D. Unusual skin findings in a patient with liver disease. *CMAJ* 2002;166(12):1567.

[The author responds:]

I am grateful to Dwight Peretz for his insights related to traditional Asian medical practices. I agree that moxibustion, coining, cupping and other traditional practices are extremely common, both in Asia and among immigrant populations in Canada. Nonetheless, the stigmata of these practices remain unfamiliar to many clinicians who have not had the benefit of practising in Asia or among Asian immigrant populations. Recognition of these clinical signs for

what they are will allow clinicians to avoid misdiagnosis and may provide insights into the health beliefs of individual patients. I hope that the publication of the photographs in my article¹ has helped to familiarize clinicians with the skin manifestations of these traditional techniques.

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Reference

1. Fisman D. Unusual skin findings in a patient with liver disease. *CMAJ* 2002;166(12):1567.

Debate over group B streptococcal recommendations

The Canadian Task Force on Preventive Health Care has made recommendations on 3 strategies to prevent group B streptococcal (GBS) infection in neonates.¹ The recommendations are not consistent with the information provided in the article and are at odds with the existing national guidelines.²

Strategy A is designed to screen all women at 35-37 weeks' gestation for GBS colonization and treat colonized women with risk factors. Strategy B is designed to screen all women and treat all who are colonized. And strategy C is designed to treat on the basis of risk factors alone. The task force's preferred strategy is strategy A. Strategy C is deemed to be the least favoured strategy because there is insufficient evidence to evaluate its effectiveness. However, strategy C would lead to treatment of the same group of infants as strategy A and those whose mothers have risk factors but have a negative screening result. This strategy would also result in treatment when the screen failed to identify colonization of the mother and when the mother was colonized after screening.

Women presenting in preterm labour will be largely unscreened be-

cause of the timing of the screen and may require treatment in any case. Those with GBS infection in a previous pregnancy should be treated in any case. Maternal fever in labour would be treated in the interests of both mother and baby. Therefore, strategies A and B would result in all pregnant women being screened at significant cost.

On the basis of the information presented by the task force, strategy C appears to be the most clinically efficient and cost-effective way of preventing GBS infection in neonates.

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1. Prevention of group B streptococcal infection in newborns. Recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2002;166(7):928-30.
2. Society of Obstetricians and Gynaecologists. Statement on the prevention of early-onset group B streptococcal infection in the newborn. *J Soc Obstet Gynaecol* 1997;19:751-8.

[The Canadian Task Force on Preventive Health Care responds:]

R.J. Morrow does not specify the way in which there is an apparent mismatch between our recommendations and the information we presented in our report on preventing group B streptococcal (GBS) infection in newborns,¹ but in the interests of complete clarity we would like to direct readers to the full technical document, which is available at www.ctphc.org/Full_Text/CTF_GBS_TR_final.pdf.

In reply to Morrow's comment regarding inconsistency among national guidelines, we can only reply that we followed an evidence-based process to determine the effectiveness of the 3 strategies and found insufficient evidence to recommend for or against strategy C. Other factors that might be used in decision-making include cost, feasibility and patient preferences, and do not factor directly into our recommendations, although we attempt to address them in other parts of our article.

We disagree with Morrow's statement that strategies A and C could be

used to treat the same group of women. If strategy C were adopted, all women with at least one risk factor would receive intrapartum prophylaxis. Many of these women would be negative for group B streptococcus and therefore a larger number of women would be exposed to antibiotics than in strategy A. Finally, our recommendation statement only addresses women at or close to term gestation.

Many organisms other than group B streptococcus cause early-onset sepsis. Chorioamnionitis carries a high risk for neonatal infection, and women with this condition should receive appropriate intrapartum treatment regardless of their GBS colonization status.

Finally, it should be made clear to health care providers and parents that none of these strategies can prevent all cases of early-onset GBS infection.

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Reference

1. Prevention of group B streptococcal infection in newborns. Recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2002;166(7):928-30.

Telehealth: Is it safe?

We thank Patrick Potter for taking the time to comment on telehealth in his recent letter.¹ He may not realize that the goal of triage is not to make a diagnosis. As his anecdote illustrates, it is foolhardy to attempt to "make the diagnosis over the phone." Rather, the goal of telephone nursing assessment is symptom triage. Clearly, it is not diagnostic certainty that allows for sorting to be accomplished, and this cannot be done by rote or scripted automations. Trained and experienced nurses, who listen reflectively, aided by tools that prevent gaps in information gathering and documentation, have been providing this function for at least 15 years.² No suit against a triage provider has successfully shown an inability to sort out

the emergently ill. This safety record stands in the highly litigious atmosphere of our US neighbours, where millions of triage calls are conducted annually (Raul Seballos, Cleveland Clinic, Cleveland: personal communication, 2002). The originators of this type of triage were pediatricians, seeking relief from the onerous after-hours phone calls that plague most acute care physicians.

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References

1. Potter PJ. Telehealth revisited [letter]. *CMAJ* 2002;166(11):1396.
2. Poole SR, Schmitt BD, Carruth T, Peterson-Smith A, Slusarski M. After-hours telephone coverage: the application of an area-wide telephone triage and advice system for pediatric practices. *Pediatrics* 1993;92(5):670-9.

Hyponatremia and SIADH

In their article on hyponatremia,¹ Haralampos Milionis and colleagues do not mention an interesting diagnostic tool: the detection of high-molecular-weight forms of vasopressin. The presence of this in plasma, sometimes in large amounts, is highly suggestive of the syndrome of inappropriate secretion of antidiuretic hormone (SIADH) associated with a carcinoma of the lung.²⁻⁴

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2. Yamaji T, Ishibashi M, Hori T. Proreninogen in human blood: a possible marker of ectopic vasopressin production. *J Clin Endocrinol Metab*