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Barometer falling

With regard to Patrick Sullivan's article on the military physician staffing crisis,[1] the Canadian Forces have access to a large pool of retired, well trained and experienced physicians whom they could employ as civilians on bases located in Canadian cities. This would free up military physicians to serve overseas.

Incidentally, the 3 flight surgeons pictured as experiencing the symptoms of hypoxia are located in a decompression or hypobaric chamber, not a hyperbaric chamber. By creating a vacuum in the chamber the effects of altitude are simulated. Conversely, by increasing the pressure in a recompression or hyperbaric chamber the effects of increased pressure as experienced by divers may also be reproduced.

Commander Ian Buckingham (Ret.), MB BS, MMM, CD
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Update on the new virus in Malaysia

A *CMAJ* public health article recently described the emergence of a new morbillivirus causing febrile encephalitis among pig farmers and abattoir workers in Malaysia.[1] As of Apr. 27, 1999, 257 cases have been reported. Almost half of those affected died. Several cases were also reported in Singapore among workers handling pigs imported from Malaysia. The virus, formerly known as Hendra-like virus because of its similarity to an equine morbillivirus identified in Australia in 1994, is now called Nipah virus.[2] Most human cases continue to be connected to exposure to pigs. In an effort to control the outbreak, approximately 890 000 pigs have been killed in Malaysia, transport of pigs within the country has been banned, and education has been provided about contact with pigs and use of protective equipment. The incidence of infection in humans has been decreasing, from a peak of 46 cases between Mar. 13 and 19 to 4 cases between Apr. 10 and 16. Nipah virus infection has been confirmed in a necropsied dog. No human-to-human transmission has been reported to date.

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New method for prostate exam

I would like to propose an alternative to the conventional way of performing the digital rectal examination for palpation of the prostate. I believe this method is more comfortable for the examiner and thus may facilitate the detection of abnormalities. A search of the literature has shown no prior reference to this method.

Conventionally, examination of the prostate is performed with the patient in the left lateral or left lateral prone position (Sim's position).[1,2] To palpate the prostate adequately, the examiner must have the palmar surface of his or her hand facing the ventral prostate gland. The examiner must therefore pronate his or her arm maximally and may even need to turn his or her body away from the patient to feel the area. This position is unnecessarily awkward and makes it especially difficult to reach the prostate and the right rectal wall.

I suggest that the patient be placed instead in a right lateral or right lateral semi-prone position. Using this method, the examiner need not pronate his or her hand to the same degree. In this more natural position, the examination can be performed more easily, comfortably and reliably. Of course, the posterior rectal wall may be more difficult to palpate in the proposed position, but the emphasis of the technique is on palpation of the prostate. Once the patient's hips and knees are flexed, the examiner should stand below the level of the hips to visualize the perineum, the anal orifice and the buttocks. The remainder of the exam is then performed in the usual manner.

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Alternative views on alternative therapies

Although I can understand Drs. Ian F. Tannock and David G. Warr's frustration with limited research funding,[1] I find that their article belittles the qualities of science, which are to seek evidence and truth, wherever that search may lead. The accusation that the *CMAJ* series on unconventional therapies represents a "low point for both *CMAJ* and the Canadian Cancer Society" is an unwarranted insult, one that may be viewed as unsympathetic to the educational needs of both health care professionals and patients with cancer. Nowhere is an endorsement of these therapies implied and, quite frankly, the information provided may persuade open-minded, but sceptical, readers that evidence for their efficacy is limited.

I agree that many inappropriate quasi–scientific therapies are touted for the alternative treatment of cancer. These should be distinguished from alternative paradigms of health care, for example traditional Chinese medicine and ayurvedic medicine, which operate within a very different cultural philosophy.[2] The strength of these paradigms is that they convey a humanistic and holis-

tic approach to health care by integrating the body, mind and spirit into their diagnostic and treatment systems. The therapeutic tools used within these systems are currently being evaluated.[3] Many oriental herbs have been shown to be active as biological response modifiers when tested in the laboratory. They may be useful as adjunctive therapies for both the treatment of cancer and the reduction of side effects from chemotherapy and radiotherapy.[4] Acupuncture has been shown to modulate neurophysiologic responses and neuropeptide levels and may be useful for both symptom control and manipulation of endocrine status, cykotine production and immunocompetence.[5] The science of psychoneuroimmunology is revealing that psychological techniques, such as meditation, can modulate the immune system and levels of hormones such as melatonin (which can inhibit the division of prostate and breast cancer cells in vitro and in vivo).[6] I believe that the scientific evaluation of these alternative health care systems, including their interaction at the molecular level, is a challenge and a responsibility that should be met with enthusiasm and not shunned by physicians.[7]

To use Drs. Tannock and Warr's metaphor, patients with cancer *do* see the earth as flat, their perception clouded by the immediacy of their impending death. A holistic approach to their care is more likely to persuade them that the earth is round.

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Competing interests: None declared.

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[The authors respond:]

Dr. Sagar is concerned that our editorial may be viewed as "unsympathetic to the educational needs of both health care professionals and patients with cancer." This criticism is ill-founded — our concluding paragraph stated that the series provided useful background information for physicians.[1] Education, however, should be based on facts. Although the series gave the appearance of an evidence-based review, it did not use conventional rules

for ranking evidence. In the case of hydrazine sulfate, the highest quality data consisted of 3 negative double-blind randomized trials published in a peer-reviewed journal.[2] If this was an antineoplastic drug developed along traditional lines, there would be only one reasonable verdict: ineffective. Dr. Elizabeth Kaegi, however, concluded that the effects of hydrazine sulfate on tumour shrinkage and survival were "uncertain" and that more trials are necessary. Ill-founded conclusions considerably weaken the educational value of any article, especially one also intended for the lay public.

Patients use alternative cancer therapies to improve their chance of survival. Life-prolonging anticancer therapies developed by nontraditional means *could* exist. However, we lack a logical framework for deciding which of the endless alternative approaches should be evaluated. The evaluation of interventions that receive vocal support (laetrile, vitamin C, hydrazine sulfate) has yielded entirely negative results, yet their use persists. How will we answer the inevitable comments on trial design when the intervention is a "holistic approach" with enormous variability in delivery? The expected 1 in 20 false-positive studies will be forever touted as evidence of efficacy and subsequent negative trials will be attributed to inadequate methodology.

The scientific community has a responsibility to use wisely the money generously donated by the Canadian public to the Canadian Cancer Society.

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Corrections

A recent *CMAJ* supplement[1] contained an incorrect statement of competing interests for Dr. George Fodor. The statement should have read: "Dr. Fodor has received educational grants and speaker's fees from various pharmaceutical companies."

Reference

1. Fodor JG, Whitmore B, Leenen F, Larochelle P. Lifestyle modifications to prevent and control hypertension: 5. Recommendations on dietary salt. *CMAJ* 1999;160(9 Suppl):S29-S34.

A recent letter by Dr. Terry Polevoy[1] contained an error. It was a young woman from the Saskatoon area, not Regina, who died.

Reference

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