Flu vaccination in Alberta long-term care facilities

I wish to take issue with Margaret Russell's results and her interpretation of her findings concerning staff vaccination rates for influenza in long-term care facilities in Alberta.[1] This is not a fair or accurate representation of the situation within the Calgary region over the past 2 seasons. I am perplexed as to why such a study should be reported at this time in *CMAJ*.

The average staff vaccination rate within all Calgary long-term care facilities has improved from 44% during the 1998–1999 season (the period studied by Russell) to 75% during the 2000–2001 season. Our long-term care facilities comprise a heterogeneous mix of 27 public, private and voluntary institutions.

The average staff vaccination rate at 25 long-term care facilities was 63% in 1999–2000. The average influenza vaccination rate for residents of long-term care facilities was 93% in 2000–2001 and 94% in 1999–2000. Much of this improvement was due to the introduction and adoption of a comprehensive standardized approach to the management of influenza and institutional outbreaks in the Calgary region since 1998. Recognition by attending physicians and nurses of influenza outbreaks in the community and seasonal mortality trends in long-term care facilities was facilitated directly by regionalization of health care services.

To state that "staff vaccination rates in Alberta long-term care facilities are unacceptably low" without qualifying the period of study is unhelpful. It may not be possible to improve significantly on our average resident vaccination rates but we expect continued improvement in staff vaccination rates. We are also targeting health care workers who are in contact with senior citizens living outside of long-term care facilities, such as in lodges and supported living environments. As a postscript, our surveillance for influenza failed to detect a single outbreak of influenza A within any long-term care facility in this region during the past season.

Paddy Quail
Division Chief
Continuing Care
Calgary Health Region
Calgary, Alta.

Reference

1. Russell ML. Influenza vaccination in Alberta long-term care facilities. *CMAJ* 2001;164(10): 1423-7.

[The author responds:]

Paddy Quail expresses concern that the period of the study was not provided; however, this was clearly stated in the article.[1] He is also concerned that the data presented for Alberta are not a fair representation of the current situation in Calgary. The paper described the situation for the entire province at the time of the study, and the aggregated Alberta data included information provided by Calgary long-term care facilities for the period 1998–1999. A summary of the study findings and recommendations was sent to every medical officer of health in Alberta immediately after the study was completed.

I congratulate the Calgary Health Region on the excellent progress made in vaccinating the staff of Calgary long-term care facilities since that time.

Margaret Russell
Associate Professor
Department of Community Health Sciences
Faculty of Medicine
University of Calgary
Calgary, Alta.

Reference

1. Russell ML. Influenza vaccination in Alberta long-term care facilities. *CMAJ* 2001;164(10): 1423-7.

Too many serpents spoil the symbol

Gert Brieger's review of Gerald Hart's *Asclepius: the God of Medicine* was most interesting and rightly pointed out that Asklepios' staff with the single serpent (the karykeion) is the

Submitting letters

Letters may be submitted via our Web site or by mail, courier, email (pubs@cma.ca) or fax. They should be no more than 250 words long and must be signed by all authors. A signed copy of letters submitted by email must be sent subsequently to *CMAJ* by fax or regular mail. Letters written in response to an article published in *CMAJ* must be submitted within 2 months of the article's publication date. Letters are subject to editing and abridgement.

eLetters

We encourage readers to submit letters to the editor via the eLetters service on our Web site (www.cma.ca/cmaj). Our aim is to post by the next business day correspondence that contributes significantly to the topic under discussion. eLetters will be appended to the article in question in *eCMAJ* and will also be considered for print publication in *CMAJ*. Beginning with the Aug. 22, 2000, issue, eLetters can be submitted by clicking on the mailbox icon at the end of the HTML text of any *eCMAJ* article.

symbol of medicine. I wish there had been mention of the fact that the winged 2-serpent wand or caduceus belongs to Hermes, the messenger of the gods. It is frequently used wrongly as a symbol of medicine in pharmaceutical advertisements. The staff of Asklepios was put on a new Canadian quarter a year ago and in the newspapers it was erroneously called the caduceus, which illustrates the confusion on the subject.

H.J. Scott
Cardiovascularthoracic Surgeon (retired)
Montreal, Que.

Reference

1. Brieger GH. Popular mythology. *CMAJ* 2001; 164(10):1471-2.

Hereditary nonpolyposis colon cancer

I am concerned that the recommendation statement from the Canadian Task Force on Preventive Health Care on colorectal cancer screening[1] did not mention the need to screen people with hereditary nonpolyposis colon cancer for other types of cancer. In some kindreds with hereditary nonpolyposis colon cancer, extracolonic malignancies including endometrial, bladder, stomach and other cancers have been reported.[2] It is important to mention that other surveillance measures in addition to colonoscopy should be considered for people at risk of developing hereditary nonpolyposis colon cancer;[2] the article leaves the false impression that a colonoscopy is the only screening modality required in such kindreds.

Edmond G. Lemire
Medical Geneticist
Royal University Hospital
Saskatoon, Sask.

References

1. Colorectal cancer screening: recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2001;165(2):206-8.
2. Lindor NM, Greene MH. The concise handbook of family cancer syndromes. Mayo Familial Cancer Program. *J Natl Cancer Inst* 1998;90(14): 1039-71.

[One of the authors responds:]

We appreciate Edmond Lemire's comments and agree that people with hereditary nonpolyposis colon cancer have an increased risk of extracolonic malignancies. However, the recently published recommendations from the Canadian Task Force on Preventive Health Care[1] were limited to screening for colorectal cancer in people at average and high risk. Thus, screening for other types of cancer, even in people with hereditary nonpolyposis colon cancer, was beyond the scope of this review.

Robin S. McLeod
Professor of Surgery
University of Toronto
Toronto, Ont.

References

1. Colorectal cancer screening: recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2001;165(2):206-8.

Don't forget anserine bursitis

The article by Jack Taunton and Michael Wilkinson on anterior knee pain[1] covered most conditions seen at sports medicine clinics but omitted one frequently misdiagnosed condition, anserine bursitis, which is rare in athletes.

It is easily recognized in overweight, middle-aged or elderly women with anterior knee pain and well-localized tenderness, sometimes with puffiness, about 5 cm below the knee joint on the medial portion of the anterior tibia.[2] Osteoarthritis of the knee is often present and distracts from consideration of anserine bursitis. Local injection of corticosteroids gives good relief with confirmation of the diagnosis.[3]

Harold H. Fireman
Rheumatologist
Ottawa, Ont.

References

1. Taunton JE, Wilkinson M. Rheumatology: 14. Diagnosis and management of anterior knee pain. *CMAJ* 2001;164(11):1595-601.
2. Larsson LG, Baum J. The syndrome of anserine bursitis: an overlooked diagnosis. *Arthritis Rheum* 1985;28:1062-5.
3. Klippel JH, Weyand CM, Wortman R, editors. Anserine bursitis. In: *Primer on rheumatic diseases*. 11th ed. Marietta (GA): Longstreet Press; 1998.

[One of the authors responds:]

Harold Fireman makes a good point regarding pes anserine bursitis in his letter concerning our article.[1] We see this condition in hurdlers, steeplechasers and people who run downhill. If it persists you need to consider a traction stress fracture at the site and order a bone scan. If the bone scan is very hot then you will need a CT scan, as I have seen a few of these go to a completed fracture. For the true bursitis, local injection certainly can be effective and I have had good results with topical 10% diclofenac. The patient needs to work on hamstring stretching and quadriceps–hamstring strengthening.

Jack E. Taunton
Professor and Director
Allan McGavin Sports Medicine Centre
University of British Columbia
Vancouver, BC

Reference

1. Taunton JE, Wilkinson M. Rheumatology: 14. Diagnosis and management of anterior knee pain. *CMAJ* 2001;164(11):1595-601.

Longer waits for breast cancer surgery in Quebec could be good news

Nancy Mayo and colleagues suggest that the waiting time between diagnosis and first surgery for breast cancer increased in Quebec between 1992 and 1998.[1] Although this may be due to the recent reform of health services, an alternative or complementary explanation is that more women are being diagnosed following screening by mammography.

With more screening, the proportion of tumours detected early, when they are small and nonpalpable, should increase. The investigation of such cases often requires several procedures, and the referral process is likely to be associated with delays that would not be