units that will be effective in approximately 90% of the population, these dosage units are excessive for many young patients and may be inappropriate for frail elderly people. Most monographs in the *Compendium of Pharmaceuticals and Specialties* list the number of fixed-strength tablets or capsules that may be given in a 24-hour period. If an elderly 50-kg woman and a 100-kg man each consume one capsule they are certainly not getting the same dose. The presentation of dosage should include a measure of body weight or body surface area.

The Ontario Drug Benefit Formulary has taken on the role of paymaster for the pharmaceutical industry. Pharmacists are discouraged from finding creative ways to tailor medications to the specific needs of patients.

Recent advances in pharmacogenomics have produced much excitement concerning the future of personalized medicine. However, customized doses for elderly patients are needed today. The technology to deliver personalized medications is available now, but unfortunately it is seldom used by pharmacists or requested by physicians.

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Reference
1. Fischbach MS, Gold JL, Lee M, Dergal JM, Litner GM, Rochon PA. Pill-splitting in a long-term care facility. *CMAJ* 2001;164(6):785-6.

[Two of the authors respond:]

In an ideal world and using existing technology, every hospital, pharmacy and physician's office would be equipped with a database capable of computing suitable starting and maintenance doses for each patient's medications on the basis of the patient's age, body weight, surface area and creatinine clearance rate. The doses could subsequently be modified on the basis of therapeutic effect. This would allow physicians to prescribe and pharmacists to dispense essential therapies in a truly personalized and standardized manner. Effective disease management would thereby be maximized and adverse events would be curtailed. Pharmacogenomics may promise even further advances, but its practical applications will likely not be implemented in the near future.

Until the pharmaceutical industry manufactures medicines in formulations that allow for such customized dosing (especially very small doses); until hospitals, pharmacies and physicians' offices invest in the infrastructure and information systems required to implement such an undertaking; and until hospital and provincial drug formularies and funding guidelines are revamped to account for variations in dosing, pill-splitting will remain an unfortunate reality.[1] This is particularly true among community-dwelling and institutionalized elderly people who so often require the "start low, go slow" strategy.

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Reference
1. Fischbach MS, Gold JL, Lee M, Dergal JM, Litner GM, Rochon PA. Pill-splitting in a long-term care facility. *CMAJ* 2001;164(6):785-6.

Give us clear, not convoluted, clinical practice guidelines

The recent article on chemoprevention of breast cancer has left me a confused general practitioner.[1] The authors refer to assessment of a woman's risk of breast cancer using the Gail index and make recommendations regarding the prescription of tamoxifen to women who have a Gail index that is greater than or equal to 1.66% over 5 years. But they point out that the Gail index has not been validated and has not been evaluated for use as a routine screening or case-finding instrument. Nowhere in the article can I find satisfactory reconciliation of these conflicting notions.

Because the Gail index has not been evaluated and validated it does not seem to me that there are sufficient grounds for publication of a high-profile article setting out official guidelines for all Canadian physicians.

As a result of the publication of this article many patients will no doubt visit their physician's office to discuss chemoprevention of breast cancer with tamoxifen. When I am faced with such patients I will be at a loss as to how to proceed, not knowing whether the advice given in the article is valid or not.

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Reference
1. Levine M, Moutquin J-M, Walton R, Feightner J. Chemoprevention of breast cancer. *CMAJ* 2001;164(12):1681-90.

After reading the guideline on chemoprevention of breast cancer,[1] I feel compelled to vent my frustration at the publication of yet another verbose, convoluted and impractical guideline for those of us in clinical practice to follow. The appendix entitled "Questions and answers on chemoprevention and breast cancer: a guide for women and their physicians" also seems totally impractical. The woman and her physician are advised to obtain the Gail index from a Web site but told that it will only be useful in determining "whether to further discuss the benefits and harms of taking tamoxifen." A woman is supposed to decide whether she feels "a tamoxifen-induced stroke would be far worse than breast cancer" or "breast cancer would be far worse than a stroke." She is then advised, "You will have to determine the value you place on the possible consequences of taking or not taking tamoxifen after a full discussion with your doctor." Like so many other *CMAJ* guidelines, this provides little assistance in the decision-making process for the physician or the patient. Am I supposed to ask my patients if they would prefer to die of

breast cancer or a tamoxifen-induced stroke?

I suggest that consensus documents be limited to 4 or 5 pages in length; they should be concise in their recommendations and should not obfuscate areas that are unclear. Peer reviewers should include clinicians and community practitioners. If the guideline document is unclear, ambiguous or unhelpful it should be sent back to the authors for revision.

Consensus documents and clinical practice guidelines are a great idea. Please keep publishing them, but always consider whether the recommendations are clear, useful and practical. Recommendations that a therapy should be used only in cases in which the potential benefits outweigh the risks are not helpful when the potential risks and benefits have not been outlined clearly.

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Reference

1. Levine M, Moutquin JM, Walton R, Feightner J. Chemoprevention of breast cancer. *CMAJ* 2001;164(12):1681-90.

[The authors respond:]

We regret that Michael Lawrence has been left confused and at a loss as to how to proceed. He feels that, because the Gail index has not been validated as a routine screening instrument, there are insufficient grounds for publication of the guideline in *CMAJ*.

The 2 committees that developed the guideline[1] felt that there is high-quality evidence from a large North American randomized trial on the potential benefit of tamoxifen for prevention of breast cancer that cannot be ignored. The Gail index was used to define entry for this trial. However, the committees felt that it was premature for family physicians to routinely apply the Gail index to all women in their practices. Although the Gail index has not been validated for routine screening, it is widely used in certain settings and is here to stay. The Gail index is familiar to oncologists specializing in breast cancer and is being used to identify women for participation in ongoing clinical trials.

The issue of the use of tamoxifen to prevent breast cancer in women is certainly topical and one that many women wonder about, particularly if they have a family member with breast cancer. The use of tamoxifen to prevent breast cancer is in evolution as we await the results of additional clinical trials. We feel, however, that the guideline published in *CMAJ* on the chemoprevention of breast cancer equips a family physician with an approach to use if a patient asks about the use of tamoxifen to prevent breast cancer. The guideline gives a critical review of the evidence on the subject and presents the current state of the art. It tells a physician how to locate and use the Gail risk index. Finally, it also recommends that if a woman wants to pursue the issue further, there are now specialized centres across Canada that can provide counselling.

John Sehmer wants a concise recommendation concerning the use of tamoxifen to prevent breast cancer. There are many situations in medicine that are not clear-cut and involve trade-offs between efficacy and side effects. In addition, patients will attach their own values to these outcomes. This guideline was developed by a multidisciplinary group of practising clinicians and breast cancer survivors. There is also a lay version of this guideline. We hope that if one of Sehmer's patients approaches him about the use of tamoxifen to prevent breast cancer or asks about the Gail index, he will have a change of heart and find that the guideline is an excellent resource.

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Reference

1. Levine M, Moutquin JM, Walton R, Feightner J. Chemoprevention of breast cancer. *CMAJ* 2001;164(12):1681-90.

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