mains a serious problem in Canada.

First, trends in reported cases of AIDS can be accurately assessed only by examining numbers adjusted for reporting delay. We perform this adjustment in our year-end reports, and from the 2001 report it is clear that although there was a steep decline in reported AIDS cases between 1995 and 1998 (from 1713 to 701 cases, a 59% decrease), this rate of decline slowed over the next period (from 701 cases in 1998 to 452 in 2001, a 36% decrease) (Fig. 1).[2]

Second, although the number of reports of positive HIV test results decreased from 2987 in 1995 to 2119 in 2000, the number increased to 2180 in 2001 and continued to increase in the first half of 2002 (1193 v. 1088 reported in the first half of 2001) (Fig. 2).[3] Furthermore, positive HIV test reports represent only those who came forward for testing and whose diagnosis of HIV infection was subsequently reported; they do not represent the annual number of new HIV infections (incidence). We estimate national HIV incidence through a separate process, and our most recent estimate is that 4190 new infections occurred in 1999, a number essentially unchanged from our estimate of 4200 in 1996.[4]

Third, of positive test results reported for adult females during the first half of 2002, the proportion for those 15 to 29 years of age was 35.4% (104/294), not 42.6% as reported by Sullivan. The figure of 42.6% refers to the proportion of females among all positive HIV test results reported for the 15- to 29-year age category during the first half of 2002.[3]

National HIV and AIDS surveillance data and other available evidence[5] indicate that HIV infection continues to be a significant public health problem in Canada, one that is increasingly affecting women and socially and economically disadvantaged groups such as Aboriginal people.

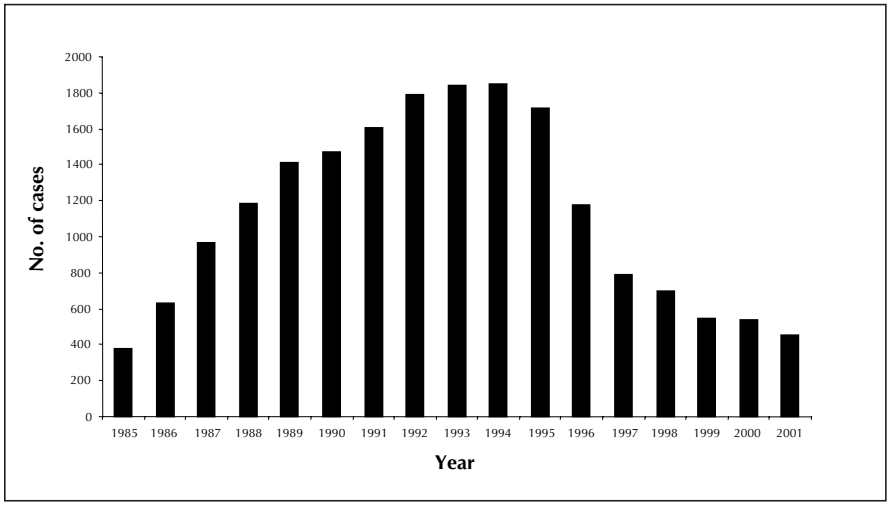

Fig. 1: Reported cases of AIDS by year of diagnosis in Canada, to Dec. 31, 2001, adjusted for reporting delay.

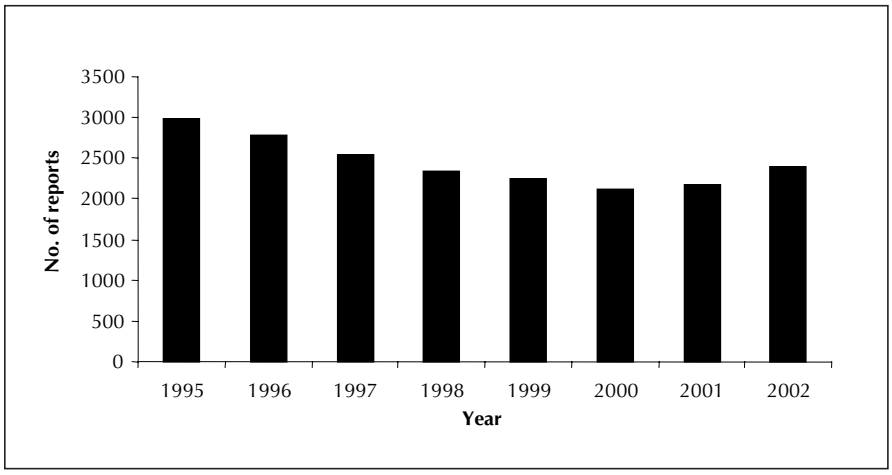

Fig. 2: Number of reports of positive HIV tests in Canada by year of test. The 2002 value is an estimate that represents twice the number of reports to June 30, 2002.

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Seeking disclosure

Because of the controversial nature of James Wright's review of cyclooxygenase NSAIDs,[1] one might have expected *CMAJ* to go to great lengths to ensure adequate disclosure of competing interests. Although Wright listed his affiliation with the University

of British Columbia Department of Pharmacology and Therapeutics, he did not mention his involvement with the Therapeutics Initiative, which is supported by BC Pharmacare. This represents a significant conflict of interest that should have been disclosed. The concomitant presentation of a contrary viewpoint would also have been welcome.

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Reference

1. Wright JM. The double-edged sword of COX-2 selective NSAIDs. *CMAJ* 2002;167(10):1131-7.

Competing interests: Dr. Maksymowych has received speaker fees from Merck and educational grants from Aventis.

[The author responds:]

My article on cyclooxygenase-2 NSAIDs[1] represents data from randomized controlled trials and my own personal interpretation of those data. I am the managing director of the Therapeutics Initiative, which holds as one of its primary tenets the maintenance of independence from government and other vested interest groups. This independence is achieved in part by a 5-year grant funding arrangement administered by the University of British Columbia and by restriction of membership on decision-making committees and working groups to people who are not employed by government or the drug industry. To maintain credibility as a source of evidence-based information, the Therapeutics Initiative follows the rule that all those involved, whether they are researching and producing reports, preparing and disseminating educational material, or voting on committee decisions, must have no competing interests.

James M. Wright
Departments of Pharmacology and Therapeutics and of Medicine
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Reference

1. Wright JM. The double-edged sword of COX-2 selective NSAIDs. *CMAJ* 2002;167(10):1131-7.

Is nothing sacred?

The Ezekiel name comes from a long and distinguished lineage of Iraqi Jews who lived in Baghdad for more than a thousand years before being dispersed around the world in the early part of the 20th century. Physicians, attorneys, merchants, scientists, bankers, professors and rabbis have proudly borne the name.

Alas, I now discover that one "Eugene," the anatomy lab technician depicted in Ronald Ruskin's story about medical school,[1] chose the name Ezekiel for the orangutan skeleton that hung in the laboratory. Ah, the ignobility of it all. I can only hope that Ezekiel the orangutan was a giant among primates.

Dan Ezekiel
Physician
Vancouver, BC

Reference

1. Ruskin R. The anatomy museum. *CMAJ* 2003; 168(2):203-4.

[The author responds:]

Dan Ezekiel points out that his surname comes from "a long and distinguished lineage." The same cannot be said for the Ezekiel in my recent story,[1] whose origins remain unknown.

As Dr. Ezekiel no doubt knows, his name can be traced to the 6th-century BC Hebrew prophet who wrote that "The hand of the Lord came upon me, and he carried me out by his spirit and put me down in a plain full of bones" (Ezekiel 37:1).

I can assure Dr. Ezekiel that Ezekiel the organgutan skeleton was indeed a great character. He watched over young and anxious medical students struggling with Death, Anatomy, and *Grant's Atlas*. His bones showed us the spaces between life and death; his primate image floating before our eyes showed us our past and our future.

Ronald Ruskin
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Reference

1. Ruskin R. The anatomy museum. *CMAJ* 2003; 168(2):203-4.

A national drug agency

Like the editors of *CMAJ*,[1] we strongly support the Romanow Commission's recommendation for a