

References

1. Warde P, Catton C, Gospodarowicz MK. Prostate cancer: 7. Radiation therapy for localized disease. *CMAJ* 1998;159(11):1381-8.
2. Crook J, Lukka H, Klotz L, Bestic N, Johnston M; Genitourinary Cancer Disease Site Group of the Cancer Care Ontario Practice Guidelines Initiative. Systematic overview of the evidence for brachytherapy in clinically localized prostate cancer. *CMAJ* 2001;164(7):975-81.

DOI:10.1053/cmaj.10430136

Drug therapy for autonomic dysreflexia

Jeff Blackmer's article on autonomic dysreflexia¹ was a useful review of an important yet poorly understood topic. Blackmer appropriately identifies non-pharmacologic measures as the first (and usually only) step needed in treatment of acute autonomic dysreflexia. He also refers to the use of pharmacologic agents, including immediate-release nifedipine. There are few published studies evaluating antihypertensive therapy for autonomic dysreflexia. Because of several reports of serious adverse reactions occurring after administration of immediate-release nifedipine, the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure has discouraged use of this drug.² We evaluated the use of captopril as an alternative to nifedipine in the treatment of hypertensive emergencies associated with autonomic dysreflexia³ and found it both safe and effective in that setting. We continue to rely on non-pharmacologic interventions as first-line therapy for treatment of autonomic dysreflexia, but consider captopril the first choice in those situations where drug therapy is required.

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References

1. Blackmer J. Rehabilitation medicine: 1. Autonomic dysreflexia. *CMAJ* 2003;169(9):931-5.
2. Joint National Committee on Detection, Evaluation

and Treatment of High Blood Pressure. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. *Arch Intern Med* 1997;157:2413-45.

3. Esmail Z, Shalansky KF, Sunderji R, Anton H, Chambers K, Fish W. Evaluation of captopril for the management of hypertension in autonomic dysreflexia: a pilot study. *Arch Phys Med Rehabil* 2002;83:604-8.

Competing interests: None declared.

DOI:10.1053/cmaj.1031913

[The author responds:]

As Hubert Anton and Andrea Townson note, there are few published studies evaluating antihypertensive therapy in patients with autonomic dysreflexia, and, as stated in my original article,¹ most of the current evidence tends to be anecdotal or relates to very small numbers of patients. Esmail and associates² studied just 5 patients, although they documented 19 episodes of autonomic dysreflexia requiring pharmacologic treatment. The success rate of captopril as a first-line agent is not as high as that of nifedipine.² Nifedipine, although widely used to treat dysreflexic episodes, has not been reported to cause adverse events in this setting,² although it has done so in other situations.

I agree that captopril should be considered an option in the pharmacologic management of autonomic dysreflexia, but given the available evidence it is difficult to state unequivocally that it should be the first choice in situations where drug therapy is required.

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References

1. Blackmer J. Rehabilitation medicine: 1. Autonomic dysreflexia. *CMAJ* 2003;169(9):931-5.
2. Esmail Z, Shalansky KF, Sunderji R, Anton H, Chambers K, Fish W. Evaluation of captopril for the management of hypertension in autonomic dysreflexia: a pilot study. *Arch Phys Med Rehabil* 2002;83:604-8.
2. Consortium for Spinal Cord Medicine. *Acute management of autonomic dysreflexia: individuals with spinal cord injury presenting to health care facilities* [clinical practice guideline]. 2nd ed. Washington: The Consortium, Paralyzed Veterans of America; 2001.

Competing interests: None declared.

DOI:10.1053/cmaj.1040016

Child's play

The analysis by Sarah Giles and Sarah Shea of head injuries in nursery rhymes, which appeared in the "Findings" section of the 2003 Holiday Review, caught the attention of not only our regular readers, but also the lay media and general public. Many people, it seems, have an interest in nursery rhymes and their subtexts, origins and hidden meanings. We publish here a small selection of the eletters that were posted with the online version of the article. The complete discussion thread can be found on eCMAJ (www.cmaj.ca/cgi/eletters/169/12/1294). — Editors

As the father of 3 daughters, I feel it is important to find and highlight for them all possible dangers. I am therefore grateful to Sarah Giles and Sarah Shea¹ for examining how head injuries are described in nursery rhymes and identifying a hitherto unrecognized but important cultural subtext of these poems. It is of course vital that children be made aware of proper emergency medical procedures should a parent sustain an injury, and I will now be teaching my preschooler the details of CPR.

In the spirit of the Giles and Shea report, I would also suggest penning physically correct nursery rhymes. My proposal for "Twinkle, twinkle little star" would be as follows:

Scintillating photons from faraway star
How we wondered what you are.
We mounted spectrosopes onto telescopes.
A plasma in hydrostatic equilibrium, you are.
Now we model them as forms of polytropes.

David Barlow

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Reference

1. Giles SM, Shea S. Head injuries in nursery rhymes: evidence of a dangerous subtext in children's literature. *CMAJ* 2003;169(12):1294-6.

DOI:10.1053/cmaj.1040165

After publication of their research on head injuries in nursery rhymes, Sarah Giles and Sarah Shea¹ might consider pursuing a monetarily significant