Advertisement woes

The March 29, 2005, issue of *CMAJ* carries a full-page advertisement for Hydromorph Contin on page 848. The advertisement states that "some patients may also experience fewer side effects than with morphine...", and this statement cites two 2 references.[1,2] In fact, the two 2 articles cited do not make this claim, or even suggest it as far as I can see. The first citation does not contain the word "hydromorphone" anywhere in the text, and neither article mentions the specific product being advertised.

It is hard for me to escape the conclusion that the advertiser knowingly sought to mislead *CMAJ*'s readers by citing this work in the hope that no-one would check the facts. That I did so in this case is merely a function of the implausibility of the claim and my interest in the area.

CMAJ is an authoritative voice in Canadian medicine. I suggest that greater steps need to be taken to ensure that every word of every advertisement in it is verifiably truthful. This is too important to be left to the advertisers themselves.

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Competing interests: I have given lectures on pain management and opioid use under the sponsorship of Purdue Pharma and have also been compensated for the recruitment of subjects for their trials of opioid analgesics.

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[The PAAB commissioner responds:]

The Pharmaceutical Advertising Advisory Board (PAAB) has a submission review process and a complaint resolution process. Both can be seen in the PAAB Code of Advertising Acceptance at www.paab.ca. If Dr. Rashiq wants to register an official complaint he can contact me directly about the process. The complaint resolution process includes an opportunity for the sponsor, in this case Purdue Frederick, to address the allegations. The PAAB Commissioner has to honour the process that has been agreed to by the PAAB voting members, and that includes the CMA.

Dr. Rashiq's complaint may have merit. I did a brief check of our files and I note that the references have been used in advertising as far back as 1997, two years before I became Commissioner. We have received no other complaints about that particular claim. The complaint resolution process would require a re-analysis of the use of these articles to support the claim in the ad. If Dr. Rashiq wants to know who looks at advertising, the PAAB has reviewed over 20 000 new advertising pieces since 1997, with few substantiated complaints.

Ray Chepesiuk
PAAB Commissioner
Mississauga, Ont.

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[The advertiser responds:]

The statement criticized by Dr. Rashiq ("some patients may also experience fewer side effects than with morphine") is fully consistent with the literature on opioid rotation that has become available over the past 15 years.

Portenoy and Coyle[1] were among the first to comment on individual patient variability in opioid response, and an early report by Galer and colleagues[2] described the management of inadequate therapeutic response to and severe adverse effects from morphine, by switching to alternate opioids — including hydromorphone.

The other cited paper[3] describes 191 patients in the Palliative Care Unit at Edmonton General Hospital, of whom 42% required a switch in opioid because of serious toxicity or inadequate analgesia. The most frequently used initial and alternative opioids were morphine and hydromorphone, respectively. Improvement in both pain levels and the primary symptom necessitating a change in opioid, occurred on conversion from morphine to hydromorphone (or other opioids).

Later studies, also published by the University of Alberta group,[4,5] further discuss the clinical role of opioid rotation, including the equianalgesic dose ratios for switching between morphine and hydromorphone.

Recently, Nauck and colleagues[6] reported on a series of patients who showed improvements in pain control and side effects when switched from morphine to controlled-release hydromorphone.

An interesting case of differential response to morphine and hydromorphone was described by Katcher and Walsh.[7] Uncontrollable itching on morphine (an infrequent side effect attributed to cutaneous histamine release) fully resolved within 24 hours of conversion to hydromorphone.

The mechanisms underlying a dif-

ferential response to hydromorphone and morphine are not established, but possibilities include: differences in metabolism — hydromorphone is metabolized primarily to hydromorphone-3-glucuronide and, unlike morphine, does not form a 6-glucuronide metabolite that has opioid activity;[8] incomplete cross-tolerance; or as yet uncharacterized differences in opioid receptor subtype activity.

We believe that the clinical evidence for individual differences in opioid response, recently summarized in a comprehensive review of hydromorphone from the Cleveland Clinic,[9] fully supports the accuracy of the statement in the advertisement criticized by Dr. Rashiq.

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Wait times affect kids too

We are pleased that Dr. Brian Postl has been named the new Federal Advisor on Wait Times.[1] Despite a mandate prescribed by the First Ministers' Health Accord of 2004 to concentrate on five key areas (heart, cancer, diagnostic imaging, joint replacement and sight restoration), we hope that Dr. Postl's experience as a pediatrician will give him insight into a 6th key area: children's surgical wait times. Children rarely need heart revascularization, cataract surgery or hip replacements, but they may need surgery for serious birth defects, cancer, traumatic injuries and a variety of other conditions, ranging from minor to life-threatening. In BC, we have compared our wait times for children's surgery with those suggested by our professional organizations and have found that only 35% of BC children undergoing elective surgery did so within recommended wait times. Among children requiring cancer surgery, only 38% had operations during weekday working hours.[2] From this we conclude that the combination of deferred elective surgery and increased out of hours emergent or urgent (cancer) surgery are the adjustments necessary to enable timely surgical treatment for children of BC. Neither approach is safe or sustainable.

The Pediatric Surgical Chiefs of Canada believe that there is much to be done for children's surgical care delivery in Canada: let's set national "benchmarks" for children's waiting times and monitor our performance.

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On behalf of the Pediatric Surgical Chiefs of Canada
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Medical care delivery

As an admirer of the invariably high standards of *CMAJ*'s lead editorials, I would like to record a small comment about the one on monitoring the quality of medical care delivery.[1] A hospital admission is frightening enough for patients, without their learning from an authoritative source that hospitals "are particularly dangerous places" and that "the overall incidence rate of adverse events that result in death, disability or prolonged hospital stay in Canadian hospitals is 7.5 per 100 hospital admissions." From this, the trembling patient would reasonably assume that 7.5% of admissions can be expected to result in one of these fearful outcomes. However, the source article for this statistic tells us that nearly one-third of these events occurred in the 12 months preceding the index hospital admission. Thus, the rate of adverse events occurring during a hospital stay was closer to 5.2%.[2]

Doctors and patients are well aware that few therapies have a 100% success rate and that perfectly appropriate treatment can be associated with unwanted outcomes. The figure we all need to know is the rate of preventable adverse events. In the study by Baker and colleagues this was 2.8%.[2] We also need to know whether the consequences of these events are really "death, disability or prolonged hospital stay." Some proportion of adverse events in the study probably resulted only in slight extensions of the patient's stay in hospital; most (56%) resulted in no impairment, minimal impairment or impairment with recovery within 1 month.[2] The 7.5% figure cited in the editorial is barely relevant and unnecessarily frightening.

Maurice McGregor
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Montréal, Que.

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