To my recollection, the Pharmaceutical Advertising Advisory Board (PAAB) has not received any formal complaints of sexism in advertising during the 21 years that I have been at PAAB. During this time, we have rejected some advertising submissions because of sexism or sex-role stereotyping. In general, advertiser focus-group testing will weed out overt violations of section 2.5 of the PAAB Code of Advertising Acceptance (available at www.paab.ca).

The Testim advertisement was approved in May 2007 and has been running in medical journals since that time. We have received no direct comments from physicians, either by written communication or by phone. At this point, we have received little input that the ad actually offends many physicians. We have re-reviewed the ad internally by 10 professionals, including 5 women, and we have found no objection to the continued acceptance of the ad. At the time of the review, the review team thought that the subject matter was directly related to the approved indication for use as shown in the Health Canada approved terms of market authorization. The manufacturer, Paladin, told us that they had performed focus testing with licensed physicians and that they had not received any negative comments.

PAAB is not a censor, and we look for relevance to therapeutics as a starting point when we review graphics. We rely on evidence to make negative rulings, including feedback on subjective ethical or moral issues. The CMA has representation on the PAAB board of directors, and I appreciate collective feedback from organized physician groups like the CMA when making review-policy decisions. Historically, PAAB has had collective informed input from the CMA about ads involving smoking, car seats and bicycle helmets, and the PAAB has set review policy accordingly.

Ray Chepesiuk BSc Phm MIB
PAAB Commissioner
Pickering, Ont.

[Competing interests: None declared.]

We agree with the point made by a number of our readers that this advertisement is completely inappropriate and does not belong in the pages of CMAJ. Indeed, we were shocked to see this advertisement in our Oct. 9, 2007, issue and immediately notified our publisher. The director of publishing promptly told the pharmaceutical company that we would no longer be accepting this advertisement. The Pharmaceutical Advertising Advisory Board (PAAB) and the advertising firm that purchased this ad were also notified of our concern.

It is important for readers to understand that the editorial team does not review specific advertisements before they appear in print, so that advertising does not influence editorial decisions. We do, however, assist with the development of advertising policies, largely related to the placement and amount of advertising in CMAJ. In this regard, we are fully supportive of the added steps taken by the publisher to ensure that advertising meets with CMAJ’s public health mission, as well as being suitable for our readership.

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6 times higher than the rate reported by Ward and colleagues. Children and young adults are at high risk for vitamin D deficiency even in sunny regions.1 3 We agree with Danielle Grenier that, in addition to heightened efforts by individual health care providers, more rigorous national surveillance is needed to ensure adequate vitamin D intake by pregnant and lactating women and to improve the health and well-being of children and youth.4

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Competing interests: None declared.

REFERENCES

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[The authors respond:]

We are pleased that our national data1 have spurred an interest in defining the vitamin D status of children and adolescents in other countries. We agree with Lippi and colleagues that focused efforts and national surveillance should be undertaken on a global scale to ensure adequate vitamin D intake among women and children.

An important distinction between our methodologies to characterize the extent of the problem and those used by Lippi and colleagues is that we sought to prospectively determine the incidence of the most advanced form of vitamin D deficiency: vitamin D–deficiency rickets. In contrast, Lippi and colleagues retrospectively reported the incidence of biochemical vitamin D deficiency, in the absence of describing whether clinical manifestations of low vitamin D levels were present in the identified cases or whether the vitamin D deficiency might have been related to liver or renal pathology. In our prospective study, all patients for whom the information was available manifested at least 1 clinical sign of rickets, such as seizures, hypocalcemia, skeletal deformities and failure to thrive. Subsequently, a diagnosis of vitamin D–deficiency rickets was sought by the reporting pediatricians, with radiographic evidence of rickets documented in 93% (87/94) of the cases for whom radiographs were available. Our prospective study documented the incidence of rickets in Canada, which inevitably is lower than the incidence of vitamin D deficiency without rickets. In Canada, screening for vitamin D deficiency by measuring 25-hydroxyvitamin D levels has led to large numbers of children being identified with low concentrations. Roth and colleagues reported that 5.9% (4/68) of children presenting to an Edmonton, Alberta, emergency department who were screened for vitamin D status were vitamin D deficient (defined as a serum concentration of 25-hydroxyvitamin D less than 25 nmol/L).2 The Edmonton data on vitamin D deficiency identified through biochemical screening are similar to the numbers reported by Lippi and colleagues.

Emerging data on the role of vitamin D in health and disease, even beyond skeletal biology, and the fact that infants, children and pregnant and lactating women have been identified as being at risk for vitamin D deficiency (whether clinically silent or not) point to the importance of heightened attention to the problem in these groups and the need for international policies to prevent the development and progression of what appears to be a widespread public health problem.

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Competing interests: None declared.

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Correction
A recent CMAJ article referred to the following website www.agreecollaboration.org, which is no longer being updated. The appropriate website for readers to consult is www.agreetrust.org. Similarly, the footnote to Table 2 should read “Details about each question and more specific explanations are available in the AGREE instrument (www.agreetrust.org).”

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