

[PAAB responds:]

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.

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[CMAJ responds:]

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.

Paul C. Hébert MD MHSc
Editor-in-Chief, *CMAJ*
Ottawa, Ont.

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[CMA's Director of Publications responds:]

We thank our readers for writing in to share their thoughts on the Testim advertisement that appeared in the Oct. 9 issue of *CMAJ*.

As *CMAJ* publisher, I have traditionally evaluated only those advertisements that have not been reviewed and approved by PAAB. This has, for the most part, proved to be an efficient process. The CMA, however, agrees that the ad in question, which was PAAB-approved, is not appropriate for publication in *CMAJ*. We have therefore altered our advertising approval process, and I will now be reviewing all new ads submitted for publication in

the journal. We reserve the right of final approval and the right to refuse any advertisement.

Adherence to CMA's core principles of editorial independence, institutional integrity and consistency with CMA's mission, vision and values ensures that our publications remain trusted and credible sources of information for physicians and others. We continue to welcome an open dialogue with PAAB and our advertisers to ensure our advertising standards are understood and upheld.

Glenda Proctor MSc
Director of Publications, CMA
Ottawa, Ont.

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Vitamin D deficiency among Italian children

We read with interest the recent article by Leanne Ward and colleagues on the incidence of vitamin D-deficiency rickets among Canadian children.¹ Using our laboratory database at the University Hospital of Verona, Italy, we recently conducted a retrospective analysis of the results of vitamin D testing in children up to and including 18 years of age that was performed at the request of the child's pediatrician between June 2004 and June 2007.

Results of serum 25-hydroxyvitamin D tests (measured by chemiluminescence, DiaSorin LIAISON automated immunoassay analyzer) were retrieved for 192 children (mean age 7.2 years, age range 1 week–17.9 years). The median serum 25-hydroxyvitamin D concentration was 121 nmol/L (limits of interquartile range [25–75th percentile] 69–188 nmol/L). Overall, 12 children (6.2%) had a serum 25-hydroxyvitamin D concentration less than 27.5 nmol/L, which was the cutoff used by Ward and colleagues to diagnose vitamin D deficiency. Our clinical chemistry laboratory serves a region of 130 400 people, 22 300 of whom are under 18 years of age. Thus, our annual incidence rate is nearly 18 cases per 100 000 children,

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.

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1. Ward LM, Gaboury I, Ladhani M, et al. Vitamin D-deficiency rickets among children in Canada. *CMAJ* 2007;177:161-6.
2. Holick MF. Vitamin D deficiency. *N Engl J Med* 2007;357:266-81.
3. Cigolini M, Miconi V, Soffiati G, et al. Hypovitaminosis D among unselected medical inpatients and outpatients in Northern Italy. *Clin Endocrinol (Oxf)* 2006;64:475.
4. Grenier D. Active surveillance: an essential tool in safeguarding the health and well-being of children and youth. *CMAJ* 2007;177:169-71.

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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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1. Ward LM, Gaboury I, Ladhani M, et al. Vitamin D-deficiency rickets among children in Canada. *CMAJ* 2007;177:161-6.
2. Roth DE, Martz P, Yeo R, et al. Are national vitamin D guidelines sufficient to maintain adequate blood levels in children? *Can J Public Health* 2005;96:443-9.

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Correction

A recent *CMAJ* article¹ 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)."

REFERENCE

1. Palda VA, Davis D, Goldman J. A guide to the *Canadian Medical Association Handbook on Clinical Practice Guidelines*. *CMAJ* 2007;177:1221-6.

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