

that all patients with hemochromatosis were closet alcoholics. Clearly, however, toxins play a role in the exacerbation and presentation of hemochromatosis. The question is probably why some people can withstand many toxins and others cannot—ie, what is the genetic predisposition?

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by e-mail

What's in a name?

I am astonished that you published the Case Report entitled "Exacerbation of hemochromatosis by ingestion of milk thistle."¹

This brief report is actually not about milk thistle at all; it is about the devastating effects of untreated hemochromatosis. In this tale, the ingestion of milk thistle simply amounts to an inconsequential sidebar.

The author's experience with herbal remedies appears to be limited. For example, she does not note, in her lengthy description of the milk thistle preparation in question, whether "200 mg" refers to the active ingredient (silymarin) or to the powdered plant. Whichever is the case, the amount taken by her patient was subtherapeutic. The usual therapeutic dose is 160 to 320 mg of silymarin twice daily.

In the sixth paragraph, the author notes that her patient's liver function tests normalized after stopping the milk thistle preparation, coincident with stopping the "moderate amounts of acetaminophen" she was ingesting. Acetaminophen is a known hepatotoxin; I have treated a number of patients in our emergency room for acetaminophen overdose, and our first concern is always hepatic damage.

Moreover, I have had patients on recommended doses of acetaminophen (4 g or less daily) who have shown signs of hepatotoxicity. In someone whose liver is already significantly damaged, the presumption that withdrawal of a known hepatotoxin is irrelevant, whereas the cessation of a known hepatoprotective substance is pivotal, stretches credulity beyond the breaking point.

At the very least, this kind of sketchy evidence should have warranted a question mark at the end of the title! In fact, an altogether more fitting title would have been "Lack of a hepatoprotective effect of milk thistle in a case of severe hemochromatosis." Frankly, I have never heard (even in herbal medicine circles) of someone seriously considering milk thistle in this situation. The treatment of advanced hemochromatosis is always, and always has been, reduction of iron load—period. I refer your readers to a summary of the beneficial and other effects of milk thistle, written by pharmacist Wendell Combest, PhD, at www.uspharmacist.com/oldformat.asp?url=newlook/files/alte/acf3007.htm.

I note that this article was peer reviewed. I would be interested to know if any of your reviewers have extensive clinical experience with the use of herbal medicines or are familiar with the literature of pharmacognosy.

The biggest problem I have with this article is that it will now go into the melting pot of PubMed citations. There, authors who have an ideological problem with herbal remedies will find it and cite it (unwittingly or otherwise) as "evidence" of yet another "bad" effect of a plant remedy. It might even be used as an excuse by some regulatory agency to ban the use of milk thistle entirely, thus removing one of the few hepatoprotective substances now available to clinicians from the therapeutic stage.

I invite—I implore!—researchers to scrutinize and analyze the effects of every single remedy in the complementary and alternative medicine repertoire. If \$1 out of every \$10 spent on researching often trivial pharmaceutical products was devoted to good research on complementary and alternative medicine, there would be a tsunami of valuable studies, many of which would indicate new and useful therapeutic opportunities.

But I hope, just as fervently, that visible and decisive titles of articles like this are reworked carefully so that they reflect the radically more ambiguous content.

—Warren Bell MD

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Reference

1. Whittington C. Exacerbation of hemochromatosis by ingestion of milk thistle. *Can Fam Physician* 2007;53:1671-3.

To be or not to be?

I would like to extend a heartfelt thanks to the authors of the study profiling students entering medical school.¹ Having just graduated from medical school, I feel that this study adequately and accurately reflects the main issues that medical students contend with when considering family medicine as a possible career choice.

I especially appreciate the articulation of the “prestige” factor when deciding on family medicine. While there is the pressure to “apply for something better,” I feel that the *type* of students that make up medical classes these days is drastically different from those that populated classrooms even just a few years ago. Because the process of gaining admission to medical school is that much more competitive, it tends to single out pupils that *thrive* on competition, prestige, and high esteem, things that are well entrenched in the Canadian Resident Matching Service’s process for subspecialty residencies.

I suggest that the selection process should somehow identify features that would predispose medical students to choose generalist specialties overall; some resilient element that persists despite over-represented exposure to subspecialty rotations during the clinical years. Admittedly, this would be a difficult task to undertake, but if we start with more family medicine-friendly students, in addition to all the other curriculum changes that need to occur (eg, family medicine rotations in urban centres as well as rural centres), then perhaps more FPs will make it out the other end.

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