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Letters ❖ Correspondance

Nothing to whine about

The problems in our health system pale in comparison with other countries. Canadian physicians should think twice about whining too loudly, as a recent study[1] published in the *South African Family Practice* journal illustrates. This survey examined South African physicians who had emigrated to Saskatchewan—218 were permanently registered there in 1996. By far the most common reasons for emigrating were fear of violence and threats to personal security, lack of a future for their children, and South Africa's uncertain political and economic future. Most had settled into a Canadian lifestyle very readily, and their children had adapted even more quickly. Fewer than a third expressed any likelihood of returning to South Africa.

Compared with the violence and instability of present-day South Africa, Saskatchewan must appear to be a paragon of peace and quiet. It is ironic that a part of Canada that cannot attract Canadian-trained physicians is so attractive to some of the brightest from elsewhere. It is also most unfortunate to see evidence of their brain drain, despite our gain, when South Africa's needs are so desperate. Reading this study about how newcomers perceive Canada made me realize, once again, that we are a privileged lot.

—Tony Reid, MD, MSC, CCFP, FCFP
Scientific Editor,
Canadian Family Physician

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To spank or not to spank

I am writing in regard to the article[1] in the May issue, "If I shouldn't spank, what should I do?" I appreciate the material presented but wish to make comments that, in some situations, can preclude the question "If I shouldn't.…"

As the father of four young children, I openly (at least in this forum) "confess" that my wife and I do spank our children to discipline them. What I mean by spanking is a couple of smacks to the buttocks with an open hand (which might result in transient redness but no lasting marks), in the context of a secure loving relationship. More importantly the criteria for spanking need to be clarified: it is to be used only when a child has intentionally disobeyed (defiant misbehaviour) and is carried out with loving action, not angry reaction. There are times when I feel like spanking but know I should not, and there are times when I regrettingly discipline with spanking because I know I should, so that my children learn that it is not OK to behave wrongly.

—Jeff Kornelsen, MD, CCFP
Mission, BC

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New approach to treating *Escherichia coli* O157:H7?

The small town of Walkerton, Ont, is dealing with an outbreak of *Escherichia coli* O157:H7 in their water supply. This enteritis, which is

frequently sporadic, generally arises from contaminated food or water. This bacteria can lead to more than just enteritis. Hemolytic uremic syndrome (HUS) can result, especially in children and seniors. About 15% of infected children will develop HUS. With the advent of peritoneal dialysis, hemodialysis, and better support, mortality from HUS has dropped from 30% to about 4% to 12%. The *Shigella* toxin seems to be responsible for HUS and its still-too-high mortality.[1]

In an unpublished article[2] (but accessible on the website), the *New England Journal of Medicine* warns against augmentation of HUS following the use of antibiotics in *E coli* O157:H7 enteritis. One hypothesis is that killed or injured *E coli* could release more of the toxin responsible for the syndrome. The only recommendation right now, except for support treatment and dialysis, is primary prevention.

Whole bowel irrigation (WBI) with high-molecular-weight polyethylene glycol (PEG-3350) solutions (eg, GoLYTELY and Colyte) has been used for many years for bowel decontamination in case of toxic ingestions. Few complications occur when it is used for preparing the bowel for radiographic examination or for surgery in either adults or children, even with cardiac, renal, or pulmonary disease. The solution is poorly absorbed from the gastrointestinal tract, even with inflammatory bowel disease, and produces no substantial changes in serum electrolytes, serum osmolality, body weight, or hematocrit.[3] Gastrointestinal obstruction, ileus, or perforation are contraindications to using WBI. Gastrointestinal hemorrhage is sometimes reported as a contraindication.[3,4]

Following a MEDLINE search, I could not find any reports of using WBI to treat *E coli* O157:H7 enteritis. Two publications, however, report success of this approach in *Clostridium difficile* enteritis.[5,6] Considering the complexity of the HUS cascade, it is doubtful that WBI will change the evolution of this syndrome once installed. It would appear logical, however, that WBI could help the organism achieve what it has already begun with diarrhea: eliminating pathogen bacteria and toxins from the gastrointestinal tract. Despite the fact that it is a purely theorical model and that contraindications should be respected, I believe that the general safety of WBI would warrant a try in a randomized clinical trial.

—Pierre Beaupré, MD, CCMF(MU)
Charlesbourg, Que

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