Response

I thank Dr Leduc for bringing up many valid points regarding the paper on multimorbidity with sensitivities (MWS).[1]

Limitations of the paper. I agree that the information provided in the article was not a comprehensive treatise on the issue. Rather, the paper was an introduction to the pathogenesis of, and approach to, many cases of contemporary chronic illness. Because of the journal's assigned word limit and the inclusion of a case history, only a small portion of the expansive area of sensitivity-related illness (SRI) was detailed. Because SRI is a new concept for many clinicians, much content was devoted to descriptions of terms—a necessity requested by the journal's reviewers. With the inability to expand further on this broad topic because of space restrictions, referral to relevant medical literature is provided to direct interested physicians to a more in-depth and referenced discussion.

I also agree that the paper does not focus solely on the practical. Again, because of the space limitations, the goal of the article was to provide an introductory clinical overview, not the complex details of patient management—which is not "cookie-cutter" and can vary among patients. As a result, I received a number of requests from family physicians in Canada who confirmed the reality of this common presentation and asked for more information on therapeutic approaches. One note, from a rural Ontario physician, stated, "Today alone I met with two patients who meet the criteria of multimorbidity and sensitivity." Another physician from urban British Columbia stated, "I have MANY patients with these symptoms ... and the negative labs and consults leave me feeling so helpless." With recognition of the underlying cause and pathogenesis of this common presentation, these physicians will now be able to explore details about the practical management of these complex cases.

Clearly, this issue is relevant to everyday primary care health providers throughout the country and requires much more discussion than can be provided in 1 brief paper. Just as a comprehensive and practical overview of the diagnosis and treatment of neurodevelopmental problems or respiratory complaints cannot be achieved in 1 case-based paper, a complete discussion of the assessment and management of patients experiencing MWS resulting from a toxicant burden cannot be achieved in a single article. This is a vast topic involving aspects from clinical toxicology, biochemistry, laboratory medicine, microbiology, and other related disciplines. However, I contend that an introduction to this emerging issue is important, and that clinical awareness of this recently recognized mechanism of illness is valuable. I am grateful for the interest of Dr Leduc and many other physicians, and offer some thoughts to further the discussion.

Knowledge translation. It might be useful to have a more detailed paper written on this topic. If *Canadian Family Physician* is interested, an invitation to an environmental health physician to prepare a detailed clinical paper might be of benefit to clinicians dealing with this problem in their offices.

There have been a number of medical conferences in other jurisdictions (eg, in the United States) where discussion of this topic has been included. A presentation or workshop on this health challenge at a Canadian meeting for family physicians might be helpful to clinicians.

Instruction on the assessment and management of multimorbidity states should be a regular component of the education and training of medical students and residents.

Quality of evidence. Finally, Dr Leduc's comments about quality of evidence (QE) are also apposite. Although I agree it is important to have high-quality evidence, traditional measures for QE are useful for some types of research and not for others. In other words, different kinds of medical research demand different kinds of evidence. Let me briefly mention a couple of the many issues.

Mechanisms of illness are not interventions that can be tested in clinical trials. All human work exploring disease pathogenesis is observational in nature and generally takes many years of surveillance. Although there is animal research that has established the generation of SRI by exposure of experimental animals to dangerous toxicants, clinical trials using humans are not possible for obvious ethical reasons.

Classical measures of QE are being challenged by the results from the human genome project and the expanding field of epigenetics. The recognition of individual dissimilarity in biochemistry, marked variation in the human biome, and individual differences in detoxification indices as a result of genomic variation, polymorphisms, and environmental factors, for example, have raised concerns about important determinants and confounders not appreciated in customary research methods.

The format of a traditional integrated review was chosen for the MWS paper because such reviews play a pivotal role in professional practice in medical issues with limited primary study and uncharted clinical territory. Accordingly, no mention of QE was provided in the paper but I confirm that observational data were the primary sources of information.

Conclusion. It was the objective of both papers on the topic of multimorbidity found in the June issue of *Canadian Family Physician* to introduce the topics of MWS and SRI to clinicians and to begin a discussion about how to move forward to address this expanding concern.[1,2] I thank Dr Leduc for facilitating further dialogue on this health challenge.

With the detailed and referenced material in the literature on this topic as cited in the paper, and the confirmatory observations of many physicians who have observed this SRI phenomenon since it was initially described in the literature by public health physician Claudia Miller in the 1990s, I respectfully suggest that the article does not represent a hypothesis; it is a review of an emerging and important field of medicine.

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Competing interests
None declared

References

1. Genuis SJ, Tymchak MG. Approach to patients with unexplained multimorbidity with sensitivities. *Can Fam Physician* 2014;60:533-8.
2. Genuis SJ. Pandemic of idiopathic multimorbidity. *Can Fam Physician* 2014;60:511-4 (Eng), e290-3 (Fr).

Correction

In the article "Physician assessments of the value of therapeutic information delivered via e-mail,"[1] which appeared in the May 2014 issue of *Canadian Family Physician*, an author was inadvertently excluded from the article. The correct list of authors is as follows:

Roland Grad MD CM MSc CCFP FCFP
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Jonathan L. Moscovici MSc

At the time this article was written, **Mr Moscovici** was a graduate student in the Department of Mathematics and Statistics at McGill University in Montreal, Que.

Canadian Family Physician apologizes for this error and any confusion it might have caused.

Reference

1. Grad R, Pluye P, Repchinsky C, Jovaisas B, Marlow B, Marques Ricarte IL, et al. Physician assessments of the value of therapeutic information delivered via e-mail. *Can Fam Physician* 2014;60:e258-62. Available from: **www.cfp.ca/content/60/5/e258.full.pdf+html**. Accessed 2014 Jun 20.

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