

matched French population. Usually, SMR is calculated by applying the mortality rates (ie, the incidence of death), and not the probability of death, in the reference population in comparison with the study cohort. In contrast to the French study, we used age-, sex-, and calendar-year specific reference rates to calculate the SMR.² This allows for more reliable estimates especially when the cohort has a long period of recruitment, because mortality rates tend to vary with time.

Kiladjian et al also report an incidence of thrombosis even lower than that observed in the French matched-control population. This statement, however, is not supported by appropriate data because a direct comparison of the incidence of thrombosis between patients and the control population is not reported.

Finally, concerning the well-known potential biases of retrospective studies, in the cohort of 396 patients followed at our centres, the rate of patients lost to follow-up was as low as 2.5%, even lower than that reported by the prospective study by Kiladjian et al (11.6%).

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Regarding the Lakkireddy et al article on death certificate completion

To the Editor:

I read with interest the article on death certificate completion by Lakkireddy and colleagues.¹ We agree that guidance on the appropriate completion of death certificates receives little attention and that not only the range of quality but, as importantly, the degree of accuracy (which is used for many public health matters) is suboptimal.

We at the University of Florida Department of Medicine and adjacent VA Medical Center hold a monthly 1-hour session with the fellows in a program called ACCESS

(Access and Continuity in the Education of Specialists). This program is meant primarily to continue the general internal medicine interests of fellows while they are in their fellowship. During the session, we review pertinent articles on all of medicine, professionalism, legal and ethical matters, as well as articles such as this one.

I prepared another case very similar to that of Lakkireddy et al, attempting to match that case's complexity and multisystem involvement. We used a scoring system based at 1 to represent a perfect or near-perfect completion of the death certificate, a score of 2 for almost perfect, 3 for an inaccurate but acceptable completion, and grade 4 for unacceptable, with the essential criterion for unacceptability being the cause of death listed as "cardiac arrest" or "arrhythmia."

When the case used by Lakkireddy et al was presented, the average score for PGY-4s (n = 9) was 2.8; the average score for the PGY-5s (n = 9) was 3.1; and the average score for PGY-6s/7s (n = 6) was 2.0. That session was immediately followed by a 30-minute discussion of the article in detail. Following that, my new case was presented for the remaining 15 minutes and the scores for the PGY-4s, PGY-5s, PGY-6/7s respectively improved to 1.7, 1.4, and 1.5. Perhaps more importantly for the group, the total percentage of optimal completion of death certificates increased from 17% before the lecture to 50% following the lecture, while the total number of unacceptable grade 4 completions dropped from 42% to 0%. The grade for the entire group before the lecture was 2.7, while the grade after this brief teaching exercise was 1.5. In discussion, the house staff agreed that more attention needed to be directed to correct completion of the cause of death and not to the mechanism of death.

This short exercise suffered from the involvement of a fairly small group (n = 24 fellows) and because only a brief single teaching program was offered. It also suffered from the assumption that the two cases were of equal complexity. Despite these criticisms, it does show that 1 hour of presentation with a pre- and postpresentation exercise can improve the quality of the death certificate as a usable instrument. Our findings are compatible with the assumptions made by Lakkireddy et al and demonstrate that even minimal effort can achieve improvement in this area.

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