IN RESPONSE: Dr. Rosen is correct. The study he references (1) was included in our analysis but was not called out in the section on renal insufficiency. This trial reported the effect of risedronate on fractures among participants with varying degrees of renal insufficiency. This study, which combined data from 9 randomized, double-blind, placebo-controlled trials, reported a reduced incidence of vertebral fractures with risedronate compared with placebo in participants with severe, moderate, and mild renal insufficiency.

Although not reported in our paper, we did collect data and calculate pooled estimates for all adverse events reported in all studies reviewed. Details on musculoskeletal and other adverse events can be found in the appendices to the full report (2). We identified between 1 and 3 studies that compared the effect of alendronate, ibandronate, pamidronate, risedronate, and zoledronic acid on myalgias, cramps, or leg pain. Statistically significant risks were observed for ibandronate (2.25 [CI, 1.57 to 3.29]) and zoledronic acid (3.67 [CI, 2.01 to 7.18]) compared with placebo.

As pointed out by Dr. Stock and colleagues, a limitation of our methods is that we did not specifically search for adverse events, but rather collected data on the adverse events that were reported in the context of our defined search strategy. However, data from the MORE trial (3) and the referenced study by Vogel and colleagues (4) are included our analyses.

Regarding questions about the use of previously published meta-analyses, our methods do not describe pooling across meta-analyses because we did not pool across meta-analyses. All meta-analyses relevant to the study questions were sought, and we described pooled estimates from these meta-analyses as reported by the original authors. When no meta-analyses were available, we pooled data if at least 3 studies were available; otherwise, we reported the results of the 1 or 2 studies identified. Also, as stated in the Methods section of our article, the studies included in each of the meta-analyses are enumerated in the complete report.

Dr. Black and colleagues erroneously state that we assigned a ratings of "good efficacy" and "fair efficacy" for the prevention of hip fractures to alendronate and zoledronic acid, respectively. We reported that each of these agents reduced the risk for hip fracture and that the level of evidence to support this assessment was good for alendronate and fair for zoledronic acid. The criteria used to define the level of evidence are detailed in the Methods section of our article. Per these criteria, however, the level of evidence for both alendronate and zoledronic acid is good, and we thank Dr. Black and colleagues for bringing this error to our attention.

With regard to the data reported in the figures for high-risk populations included in the paper and the data reported in the Appendix Figures for populations not described as high-risk, we would point out that these categories are not necessarily mutually exclusive. In addition, some meta-analyses included in this systematic review reported risk estimates for different risk groups that are not mutually exclusive. Such is the case with the meta-analysis (5) by Stevenson and colleagues. The risk estimates from this meta-analysis for high-risk groups are included in the "high-risk" figures; those for other groups are in the "not described as high-risk" group. It is possible that some of the same patients were included in the overlapping risk groups described in the report by Stevenson and colleagues. However, we do not feel that it was inappropriate for the meta-analysis by Stevenson and colleagues or our review to include data from the same patients in the non–mutually exclusive risk groups. This approach simply provides several different ways to look at the data.

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Potential Financial Conflicts of Interest: None disclosed.

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5. Stevenson M, Jones ML, De Nigris E, Brewer N, Davis S, Oakley J. A systematic review and economic evaluation of alendronate, etidronate, risedronate, raloxifene and teriparatide for the prevention and treatment of postmenopausal osteoporosis. Health Technol Assess. 2005;9:1-160. [PMID: 15929857]

Revision to the American College of Physicians' Ethics Manual

TO THE EDITOR: The American College of Physicians (ACP) has been active in issues concerning health and human rights for many years. More recently, the College has focused attention on the humane treatment of prisoners and detainees.

In October, the College's Board of Regents approved a revision to update the ACP Ethics Manual (1) as the next step in our policy development in this area. The revision was developed by the Ethics, Professionalism, and Human Rights Committee to specifically address physician participation in interrogation. The Committee believes that the general policy of the Ethics Manual needed to be updated in order for the College to continue to take a leadership role in the debates on humane treatment of prisoners and detainees.

The revised position is as follows:

Relation of the Physician to Government

Physicians must not be a party to and must speak out against torture or other abuses of human rights. Participation by physicians in the execution of prisoners except to certify death is unethical. Under no cir-

cumstances is it ethical for a physician to be used as an instrument of government to weaken the physical or mental resistance of a human being, nor should a physician participate in or tolerate cruel or unusual punishment or disciplinary activities beyond those permitted by the United Nations Standard Minimum Rules for the Treatment of Prisoners. Physicians must not conduct, participate in, monitor, or be present at interrogations,* or participate in developing or evaluating interrogation strategies or techniques. A physician who becomes aware of abusive or coercive practices has a duty to report those practices to the appropriate authorities and advocate for necessary medical care. Exploiting, sharing, or using medical information from any source for interrogation purposes is unethical.

* Interrogation is defined as a systematic effort to procure information useful to the purposes of the interrogator by direct questioning of a person under the control of the questioner. Interrogation is distinct from questioning to assess the medical condition or mental status of an individual.

We hope that clinicians, policymakers, and the public will find this revision and the rest of the content of the 2005 edition of the ACP Ethics Manual helpful.

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Potential Financial Conflicts of Interest: None disclosed.

Reference

1. Snyder L, Leffler C. Ethics and Human Rights Committee, American College of Physicians. Ethics manual: fifth edition. Ann Intern Med. 2005;142:560-82. [PMID: 15809467]

CORRECTIONS

Correction: Comparative Effectiveness and Harms of Treatments for Clinically Localized Prostate Cancer

In a recent systematic review (1) evaluating the comparative effectiveness and harms of treatments for clinically localized prostate cancer, the second sentence in the Data Synthesis section of the abstract should have read: "One [randomized, controlled trial] RCT enrolled mostly men without prostate-specific antigen (PSA)–detected disease and reported that compared with watchful waiting, radical prostatectomy reduced crude all-cause mortality (24% vs. 30%; $P = 0.04$) and prostate cancer–specific mortality (10% vs. 15%; $P = 0.01$) at 10 years."

Reference

1. Wilt TJ, MacDonald R, Rutks I, Shamliyan TA, Taylor BC, Kane RL. Systematic review: comparative effectiveness and harms of treatments for clinically localized prostate cancer. Ann Intern Med. 2008;148:435-48. [PMID: 18252677]

Correction: Emerging Antimicrobial Resistance in *Neisseria gonorrhoeae*

In a recent article (1) on prevention strategies for *Neisseria gonorrhoeae*, there was a misprint regarding a new type of azithromycin therapy. The sentence describing the delivery method should read: "However, a recently developed extended-release microsphere formulation delivers 2 grams of azithromycin *by sachet*."

Reference

1. Workowski KA, Berman SM, Douglas JM Jr. Emerging antimicrobial resistance in *Neisseria gonorrhoeae*: urgent need to strengthen prevention strategies. Ann Intern Med. 2008;148:606-13. [PMID: 18413622]

Correction: Screening for Osteoporosis in Men

A recent clinical practice guideline from the American College of Physicians (1) and its systematic review (2) contained errors. On pages 681 and 682 of the guideline (1), the criterion for low body weight as a risk factor for osteoporosis in men should have been only body mass index less than 20 to 25 kg/m^2, not both this body mass index and "weight less than about 40 kg," as originally stated. The same criterion should have been printed in the Discussion section of the systematic review (2).

References

1. Qaseem A, Snow V, Shekelle P, Hopkins R Jr, Forciea MA, Owens DK. Clinical Efficacy Assessment Subcommittee, American College of Physicians. Screening for osteoporosis in men: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 2008;148:680-4.
2. Liu H, Paige NM, Goldzweig CL, Wong E, Zhou A, Suttorp MJ, et al. Screening for osteoporosis in men: a systematic review for an American College of Physicians guideline. Ann Intern Med. 2008;148:685-701.