Allocation of health resources

We agree with Dr. Gross's assessment (*Can J Surg* 2002; 45[1]:8) that administrative database information is limited in clinical detail and only partially describes how a patient receives health services. In essence we take licence to paraphrase Dr. Gross in saying that better information should lead to better decisions (spanning the spectrum from patient care to health system organization). The practical difficulty in implementing this improvement is that more complete data and the ability to translate data into information and intelligence is very expensive. Obtaining additional resources for infomatics competes with the need to provide actual patient care (to diminish waiting lists for example). In such a situation, administrative data, including physician claims have been increasingly employed by health care services researchers in studies of outcomes, effectiveness, appropriateness and utilization of health care services. The use of administrative data has been facilitated by improved understanding of their features and advantages, including their readiness to be analyzed, their low cost for obtaining a large volume of historical data, their wide geographic coverage and their relatively complete and accurate capture of episodes of patient contact with the health system.

We in the medical community can start by recognizing that clinicians make daily decisions based on partial and sometimes quite poor information. As such, both in daily practice and when reviewing studies such as ours about the health system, waiting for the perfect, complete set of data before making decisions is not practical. Making required decisions based on incomplete information, stating the limitations to the available information and promoting specific improvements required to make better decisions may be a preferable strategy for improving medical information systems. This approach is neither novel nor revolutionary. The medical community has used this approach for decades in patient care and will continue its use in the future.

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Percutaneous drainage for liver hydatid cysts

We read with interest the article by Aygün and associates (*Can J Surg* 2001;44[3]:203-9) on the PAIR (puncture, aspiration, injection, reaspiration) method of treating liver hydatid cysts. Their data are consistent with those in other recent reports, showing that the use of PAIR is widespread and is increasing, especially in countries where hydatid disease is endemic. The technique is reported to be inexpensive and highly effective, relatively safe and associated with low complication, recurrence and death rates compared with surgery.[1]

The safety and effectiveness of the PAIR technique, however, have not been fully established. Aygün and colleagues reported no recurrence or dissemination during a 14 to 36-month follow-up, but they did not comment on the development time of peritoneal cysts, a grim consequence of spillage during needle puncture. The presentation of peritoneal echinococcosis typically occurs 4 to 15 years after the original treatment,[2] far beyond the relatively brief follow-up in their article. A significant proportion of hydatid cysts communicate with the biliary tree.[3] Cyst injection of scolicidal agents, a key element of PAIR, may cause sclerosing cholangitis, a feared consequence of scolicidal entry into the bile ducts. In open surgery, unlike the PAIR method, there is an opportunity to identify and protect cyst–biliary communications before scolicidal agents are introduced.

Claims advocating PAIR as a safe and effective alternative to surgery for hydatid disease should be closely studied. Aygün and colleagues used serologic testing and ultrasonography for postoperative follow-up but did not provide details about the long-term diagnostic implications of these investigations. The most frequently used serologic tests are indirect hemagglutination, enzyme-linked immunosorbent assay, immunoelectrophoresis and co-electrosynthesis. Since antigen preparations are not well defined, results vary from one laboratory to another. A judicious association of methods confirms the diagnosis in 80% to 94% of hepatic and 65% of pulmonary cases of hydatidosis.[4] Follow-up by ultrasonography can demonstrate recurrence in up to 22% of patients postoperatively.[5] Without more detailed and extensive follow-up data from the series of Aygün and colleagues it is difficult to fully accept their conclusions, particularly the suggestion that PAIR be considered a first-line therapy in selected patients with liver hydatid cysts. PAIR may be the best available option in geographic areas where the quality of surgery and perioperative care are compromised by widespread social and economic distress. Conclusive comparison of PAIR with surgery (the only established treatment for