systolic blood pressure slowly receded from 230. This put me squarely in the first group of nay-sayers to IV epinephrine for the non-moribund patient group.

Interestingly, there were an equal number of physicians who were in the alternative camp of considering IV epinephrine as a first-line agent, even in the moderate anaphylaxis patient. These were experienced emergency physicians, many from teaching or academic settings. The difference in practice was quite striking. In the Discussion section of this article,[1] I was surprised to see the relative paucity of case reports and research on this topic, as well as the conflicting recommendations available on when to move to IV epinephrine. This is certainly an area that bears some further research and clinical scrutiny. I thank Dr. Shaver and colleagues for presenting this interesting case report.

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References

1. Shaver KJ, Adams C, Weiss SJ. Acute myocardial Infarction after administration of low-dose intravenous epinephrine for anaphylaxis. Can J Emerg Med 2006;8(4):289-94.
2. Simons FE, Gu X, Simons KJ. Epinephrine absorption in adults: intramuscular versus subcutaneous injection. J Allergy Clin Immunol 2001;108(5): 871-3.

Erratum

There was an error in the Diagnostic Challenge[1] in the July issue of *CJEM*. In the last paragraph of the Commentary the article stated: "Interestingly, there have been no reports of SIPE [swimming-induced pulmonary edema] in Olympic swimmers, but there is one case published of a triathelete who developed dyspnea with slight hypoxia and right-sided pulmonary crackles some 8–9 hours after the swim." Eight to nine hours was in fact, when the patient presented to the ED, not the time frame during which symptoms developed.

Reference

1. Deady B, Glezos J, Blackie S. A swimmer's wheeze. Can J Emerg Med 2006; 8(4):281; 297-8.

Letters will be considered for publication if they relate to topics of interest to emergency physicians in urban, rural, community or academic settings. Letters responding to a previously published *CJEM* article should reach *CJEM* head office in Vancouver (see masthead for details) within 6 weeks of the article's publication. Letters should be limited to 400 words and 5 references. For reasons of space, letters may be edited for brevity and clarity.

Les lettres seront considérées pour publication si elles sont pertinentes à la médecine d'urgence en milieu urbain, rural, communautaire ou universitaire. Les lettres en réponse à des articles du *JCMU* publiés antérieurement devraient parvenir au siège social du *JCMU* à Vancouver (voir titre pour plus de détails) moins de six semaines après la parution de l'article en question. Les lettres ne devraient pas avoir plus de 400 mots et cinq références. Pour des raisons d'espace et par souci de concision et de clarté, certaines lettres pourraient être modifiées.

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