and does not register nondrug trials.³ Both of these statements are incorrect. ClinicalTrials.gov encourages and accepts the registration of any observational or interventional studies with health or biomedical outcomes in humans; trials of any intervention, such as drugs, devices and behavioural interventions; and trials conducted anywhere in the world by any sponsor. In addition to providing a unique identifier for each registered study, ClinicalTrials.gov offers quality control for trial data, a Web-based data entry and update tool (<http://prsinfo.clinicaltrials.gov/>) and a sophisticated search function.

Deborah A. Zarin

On behalf of the ClinicalTrials.gov team
National Library of Medicine
National Institutes of Health
Bethesda, Md.

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3. Bisby MA. Registration of randomized controlled trials (RCTs) funded by CIHR [letter]. Available: www.cihr-irsc.gc.ca/e/28921.html (accessed 28 Oct 2005).

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[The CIHR responds:]

The memorandum to which Deborah Zarin refers was sent in early September 2005 to warn researchers whose trials were funded by CIHR that they should

immediately register their trials with ClinicalTrials.gov. The registry used by CIHR since 2004, International Standard Randomised Controlled Trial Number Register-Current Controlled Trials Registry (ISRCTN-CCT), was not recognized by the majority of members of the ICMJE, including *CMAJ*, because it did not have a "not-for-profit" status. Failure to register with ClinicalTrials.gov could have compromised researchers' ability to publish their trial results.

The statements about ClinicalTrials.gov in the memorandum described the situation that existed in 2004, and were provided to explain why at that time CIHR chose to register the trials that it funds with ISRCTN-CCT, rather than with ClinicalTrials.gov. These statements were not intended to describe the current state of ClinicalTrials.gov, and I deeply regret the misunderstanding. CIHR endorses ClinicalTrials.gov as a high-quality public trials registry.

Since I wrote the memorandum in early September, the ISRCTN-CCT registry has acquired not-for-profit status, and now complies with the ICMJE requirements. CIHR will therefore continue to register the trials that it funds with the ISRCTN-CCT. CIHR is also working with the World Health Organization to establish a global system for trials registration, which will link the various public registries to improve access and reduce duplication.

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Reducing procedural pain

We were most dismayed to read of the use of a placebo in a study of analgesia and the success rate of cannulation when a topical anesthetic was used on children requiring venipuncture.¹ It would seem unethical to expose any patient to unnecessary procedural pain when the efficacy of available topical anesthetics has been well established and such products are currently part of care.²⁻⁵

Further, in this study, liposomal lidocaine is not compared with the known effective and available options currently used for this patient population. It is predictable that longer and more attempts at cannulation are required in the absence of any effective topical anesthesia. Although the potential difficulty of cannulation when there is either vasodilation or constriction caused by other topical agents is acknowledged, an ethically acceptable trial design should have incorporated one or more comparison arms using known effective topical anesthetics.

The use of a placebo in this study is deplorable. It points to the need for researchers and the research ethics boards who approve their studies to be cognizant of trial designs that allow individuals of any age to be exposed to suboptimal analgesia when known effective agents exist. Of interest, the first reference cited by the authors examines the ethics of analgesic trials in infants and children and clearly censures this model of placebo-controlled trial.⁶

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Mécanisme de présentation des lettres

Le site amélioré des lettres du *JAMC* est désormais le portail de réception de tous les textes destinés à la chronique Lettres. Pour rédiger une lettre, consultez un article sur le site www.jamc.ca et cliquez ensuite sur le lien «Lettres électroniques : répondre à cet article», dans la boîte en haut à droite de l'article. Toutes les lettres seront étudiées pour une éventuelle publication dans le journal imprimé.

Les lettres répondant à un article publié dans le *JAMC* sont plus susceptibles d'être acceptées pour publication imprimée si elles sont présentées dans les deux mois de la date de publication de l'article. Les lettres acceptées pour publication imprimée sont révisées en fonction du style du *JAMC* et raccourcies au besoin (elles doivent habituellement compter au maximum 250 mots).

- peripheral intravenous catheter insertions in children. *Pediatrics* 2004;113(3):e217-20.
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DOI:10.1503/cmaj.1050154

[The authors respond:]

Conrad Fernandez and Gerri Frager's claim that it is wrong to expose patients to "unnecessary procedural pain" would be correct if in the practice of emergency pediatrics children routinely received EMLA,[®] Ametop[®] or similar products. In reality, most venipunctures in Canadian pediatric emergency departments are performed without any local anesthetics. In initiating this study, the question that our research ethics board and ourselves had to ask was "What is the routine, standard practice in our emergency department"? In our hospital, children did not routinely receive topical anesthesia. The reason was that it was believed to interfere with cannulation success. Since previous studies had not addressed this question, a placebo-controlled trial was necessary to disprove this belief.

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Getting a grip on waiting lists

David Hadorn's analysis¹ fails to distinguish between waiting lists for diag-

nostic procedures (such as MRI) and those for therapeutic procedures. Diagnostic information is often required to confirm the presence of disease and assess its severity, and only when this information becomes available can the patient be appropriately queued for treatment. Long wait times for diagnostic tests are counterproductive and costly, both to the patient in terms of morbidity and disease progression and to the medicare system in terms of wasteful use of "second best" tests. A six-month wait for an MRI to confirm suspected multiple sclerosis is no more reasonable than a similar wait for a blood test to confirm suspected anemia. The Western Canada Waiting List project failed to statistically validate its MRI prioritization tool and has not endorsed it for general use. MRI prioritization does not work well simply because the severity of disease (and therefore the urgency of the test) is not accurately known until the test is done. The only practical and ethical way to address MRI wait lists is to provide adequate capacity for demand. The Alberta Imaging Advisory Committee pegged that capacity at 62 exams/1000 people/year.² Alberta is the only province to approach that capacity. Sadly, Ontario, which maintains an absolute statutory monopoly over MRI services, provides for only half the needed capacity.

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 Ottawa Hospital (General Campus)
 Former Chair, MRI Panel, Ontario
 Wait List Project
 Former member, MRI/CT Expert
 Panel, Ontario Wait Time Strategy
 Ottawa, Ont.

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2. Companion to Alberta Diagnostic Imaging—Within a Framework of Reform, Imaging Advisory Committee, Calgary, Alberta, 2002.

DOI:10.1503/cmaj.1050180

[The author responds:]

I agree that MRI and other diagnostic

procedures are not well-suited to the priority criteria approach. However, I don't agree that "the only practical and ethical way to address MRI wait lists is to provide adequate capacity for demand."

Demand bears no necessary relationship to need or benefit, and convincing evidence that MRIs lead to improved health outcomes (e.g., longer life, less pain) should be provided before MRI supplies are increased. Unfortunately, the radiology research community has been slow to produce (or even to seek) such evidence. Indeed, we were unable to find any relevant studies in the MRI literature during the initial portion of the Western Canada Waiting List project. This was some years ago, but I am not aware that the situation has changed much in the interim.

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 Priority Criteria Project
 Former Research Director of the
 Western Canada Waiting List Project
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DOI:10.1503/cmaj.1050202

Corrections

The DOI attached to a recent letter¹ should have been DOI:10.1503/cmaj.1050093.

REFERENCE

1. Lexchin J. A hypertensive snow bird [letter]. *CMAJ* 2005;173(11):1357.

DOI:10.1503/cmaj.051682

In a recent research paper,¹ the answers to the individual scale items on the Hamilton Depression Rating Scale in Appendix 1 were omitted. The correct appendix is included here (see page 208).

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1. McIntyre RS, Konarski JZ, Mancini DA, et al. Measuring the severity of depression and remission in primary care: validation of the HAMD-7 scale. *CMAJ* 2005;173(11). DOI:10.1503/cmaj.050786

DOI:10.1503/cmaj.051683