Sharpening the point

Medical manuscripts tend toward the prosaic, but this does not mean that they should also be grammatically flawed. A review of many fine journals shows a high batting average for correct grammar but suggests room for improvement. Surely, the best research demands the best grammar. The following is a light-hearted appeal.

What is the dot (period) doing in the short form of the word "Doctor"? "Dr" is not in fact an abbreviation; rather, it is a contraction.[1] This means that the first and last letters are present, and as such there is no need for a dot. The same is true when "Mister" and "Missus" are shortened. In contrast, a true abbreviation — where early letters are preserved but the last letter is gone — does demand a lovely big dot. The truncated form of "Professor" is therefore crying out for a dot ("Prof."). The shortened forms of "intravenous" and "subcutaneous" require dots for their respective abbreviations "iv." and "sc." The same is true for "et al." (the abbreviation of "et alii," meaning "other people" or "other things") and "etc." (abbreviated from "et cetera").

But wait — this means that "M.D." needs 2 dots, as does "e.g.," the abbreviation for "exempli gratia" (meaning "for example") and "i.e.," the abbreviation of "id est" (meaning "that is to say").

Call this petty, pedantic or archaic — which it largely is. Feel free to admonish us to focus on producing real research — which really we should. Regardless, spare the dot (and reserve for abbreviations) and improve the manuscript.

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DOI:10.1503/cmaj.1041741

[The senior deputy editor responds:]

P.G. Brindley shows an admirable appreciation for, ahem, the finer points of editing. The style manual of the Council of Biology Editors (now the Council of Science Editors)[1] argues for a blend of 2 tendencies in the punctuation of abbreviations, namely, the British rejection of that redundant dot after "contraction abbreviations" such as "Dr." and the North American avoidance of clutter in acronyms (AIDS) and initialisms (CIHR). *CMAJ*'s style notes, which take up more pages than anyone could imagine, eschew periods in acronyms and initialisms, as well as in abbreviations appearing in reference lists, but we indulge mild and widely accepted illogicalities such as "Dr." and "Nfld." (when we don't mean NL) and other examples that I cannot place at the end of this sentence without confusing the point. Periods are not used in units of measure, where there is little chance of misreading (6 h, 2.5 mg), and elsewhere are retained on the grounds of both logic and convention (sp., spp.). Suffice it to say we avoid abbreviations where possible.

Anne Marie Todkill
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DOI:10.1503/cmaj.051694

Clarifying a misunderstanding on clinical trial registry

The statement of the International Committee of Medical Journal Editors (ICMJE)[1,2] that clinical trial registration is a requirement for publication of trial results in their journals has captured the attention of researchers around the world. The editors noted that ClinicalTrials.gov (http://clinicaltrials.gov), an international trials registry developed and maintained by the US National Institutes of Health, met their criteria for an acceptable registry.[2] We are writing to address misunderstandings about the current policies and procedures of this registry.

A memorandum sent to Canadian health researchers by Mark Bisby, Vice-President of the Canadian Institutes of Health Research (CIHR), on Sept.1, 2005, claimed that ClinicalTrials.gov does not provide unique trial identifiers

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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.

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On behalf of the ClinicalTrials.gov team
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2. De Angelis CD, Drazen JM, Frizelle FA, et al. Is this clinical trial fully registered? A statement from the International Committee of Medical Journal Editors. *CMAJ* 2005;172(13):1700-2.
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).

DOI:10.1503/cmaj.1050201

[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 Clinical Trials.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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