and does not register nondrug trials. 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.

REFERENCES

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 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.

Mark Bisby
Vice-President, Research Portfolio
CIHR
Ottawa, Ont.

DOI:10.1503/cmaj.1050241

Reducing procedural pain

We were most dismayed to read of the use of a placebo in a study of analgescia and the success rate of cannulation when a topical anesthetic was used on children requiring venipuncture. 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.

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 analgescia when known effective agents exist. Of interest, the first reference cited by the authors examines the ethics of analgescia in infants and children and clearly censures this model of placebo-controlled trial.

Conrad V. Fernandez
Division of Pediatric Hematology/Oncology
Gerri Frager
Division of Pediatric Palliative Care
Department of Pediatrics
IWK Health Centre
Dalhousie University
Halifax, NS

REFERENCES
2. Luhmann J, Hurt S, Shootman M, et al. A comparison of buffered lidocaine versus ELA-Max before...
Getting a grip on waiting lists

David Hadorn’s analysis feet to distinguish between waiting lists for diagnostic 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.

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

REFERENCES

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.

David Hadorn Former Manager, New Zealand Priority Criteria Project Former Research Director of the Western Canada Waiting List Project Richmond, Calif.

DOi:10.1503/cmaj.1050202

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

REFERENCE

In a recent research paper, 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).

REFERENCE