in the nicotine replacement therapy literature: assessment of the double-blind in clinical trials. *Addict Behav* 2004;29:673-84.
3. Helliker K. Nicotine fix. Behind antismoking policy, influence of drug company. Government guidelines don't push cold turkey; advisers' company ties. *Wall Street Journal* 2007 Feb 8.Sect. A:1.
4. Dar R, Stronguin F, Etter JF. Assigned versus perceived placebo effects in nicotine replacement therapy for smoking reduction in Swiss smokers. *J Consult Clin Psychol* 2005;73:350-3.
5. US Centers for Disease Control and Prevention. Tobacco use among adults: United States, 2005. *MMWR Morb Mortal Wkly Rep* 2006;55:1145-8.

DOI:10.1503/cmaj.1080096

[Six of the authors respond:]

We thank John Polito for his discussion of the importance of blinding in clinical trials. Blinding is undoubtedly a key component of the validity of inferences drawn from randomized controlled trials. For this reason, it is included in tools to assess the quality of clinical trials, such as the Jadad scale.[1] In our meta-analysis of randomized controlled trials of smoking cessation pharmacotherapies, we restricted our study to double-blind trials so that only trials of the highest quality would be included.[2] We agree with Polito that maintaining blinding may be difficult, particularly if study participants experience withdrawal symptoms. However, although the importance of blinding is well established, assessing the integrity of blinding remains more controversial.

In a recent analysis of randomized controlled trials that reported tests for the success of blinding, Hróbjartsson and colleagues found that less than 2% of trials reported such testing.[3] Others have reported this percentage to be as high as 8%.[4] One reason few trial reports include tests for blinding is that it is unclear what these tests actually measure. Some have argued that such tests are often biased.[5] These tests often do not test blinding but rather test the participant's or physician's belief regarding the efficacy of the treatment.[6] Thus, the fact that patients who are randomly assigned to receive placebo and subsequently resume smoking correctly guess their allocated treatment may not be a reflection of the blinding itself but rather of their belief that the placebo is not efficacious.

Blinding plays an important role in ensuring the validity of clinical trial results. However, improved methods are needed to assess the success of blinding. Until such methods are developed, incomplete blinding is a potential limitation to most clinical trials.

Kristian B. Filion MSc
Department of Epidemiology, Biostatistics and Occupational Health, McGill University
Patrick Bélisle MSc
Division of Clinical Epidemiology, McGill University Health Centre
Lawrence Joseph PhD
Gilles Paradis MD MSc
Department of Epidemiology, Biostatistics and Occupational Health, McGill University, Montréal, Que.
Stéphane Rinfret MD MSc
Division of Cardiology, Laval Hospital, Québec City, Que.
Mark J. Eisenberg MD MPH
Divisions of Cardiology and Clinical Epidemiology, Sir Mortimer B. Davis Jewish General Hospital, Montréal Que.

Competing interests: Mark Eisenberg is a member of the Varenicline Advisory Board of Pfizer Canada Inc. No competing interests declared by Kristian Filion, Patrick Bélisle, Lawrence Joseph, Gilles Paradis or Stéphane Rinfret.

REFERENCES

1. Jadad AR, Moore RA, Carroll D, et al. Assessing the quality of reports of randomized clinical trials: Is blinding necessary? *Control Clin Trials* 1996; 17:1-12.
2. Eisenberg MJ, Filion KB, Yavin D, et al. Pharmacotherapies for smoking cessation: a meta-analysis of randomized controlled trials. *CMAJ* 2008;179: 135-44.
3. Hróbjartsson A, Forfang E, Haahr MT, et al. Blinded trials taken to the test: an analysis of randomized clinical trials that report tests for the success of blinding. *Int J Epidemiol* 2007;36:654-63.
4. Fergusson D, Glass KC, Waring D, et al. Turning a blind eye: the success of blinding reported in a random sample of randomised, placebo controlled trials. *BMJ* 2004;328:432.
5. Haynes RB, Sackett DL, Guyatt GH, et al. *Clinical epidemiology: how to do clinical practice research*. 3rd ed. Philadelphia (PA): Lippincott Williams and Wilkins; 2005.
6. Sackett DL. Measuring the success of blinding in RCTs: Don't, must, can't or needn't? *Int J Epidemiol* 2007;36:664-5.

DOI:10.1503/cmaj.1080105

Correction

In a recent research article on stable angina,[1] a sentence in the "symptoms and prognosis" section of Results that read "Among South Asian people with atypical pain, the symptom score was associated with coronary outcomes (Figure 3, unadjusted log rank test $p = 0.30$)" should have read "South Asian people with atypical pain were as likely as white people with atypical pain to experience a coronary outcome (Figure 3; unadjusted log rank test $p = 0.88$).

REFERENCE

1. Zaman MJ, Junghans C, Sekhri N, et al. Presentation of stable angina pectoris among women and South Asian people. *CMAJ* 2008;179:659-7.

DOI:10.1503/cmaj.081641

Letters submission process

To send a letter to the editor concerning a published article, visit www.cmaj.ca and click "Submit a response" at the top right-hand side of the article. All letters submitted through www.cmaj.ca will be considered for publication in the print journal. To submit a letter that does not pertain to an article in the journal, email your letter to pubs@cma.ca with a note indicating whether or not you would like it to be considered for publication.

Letters written in response to an article published in *CMAJ* are more likely to be accepted for print publication if they are submitted within 2 months of the article's publication date. Letters accepted for print publication are edited for length (usually 250 words) and house style.