tee; updated 2005 Mar 31. Available: http://gacguidelines.ca/article.pl?sid=02/07/03/2017236 (accessed 2005 Apr 28).

Competing interests: None declared.

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[The author responds:]

It is not a matter of misquoting, but it may be selective quoting. Dave Davis is correct that the GAC "guideline note"[1] mentions the overuse of antibiotics for acute otitis media. But the recommendations themselves[2] advise that symptomatic patients be treated with antibiotics; only for asymptomatic patients can antibiotics be deferred. My plea[3] was to be even more restrictive.

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References

1. Otitis media: antibiotic therapy. Guideline notes. Toronto: Guidelines Advisory Committee; updated 2005 Mar 31. Available: http://gacguidelines.ca/article.pl?sid=02/07/03/2017236 (accessed 2005 Jun 21).
2. Linsk R, Blackwood A, Cooke J, Harrison V, Lesperance M, Hildebrandt HM. University of Michigan Health System. Guidelines for clinical care. Otitis media. Ann Arbor (MI): Regents of the University of Michigan; updated 2002 May. Available: http://cme.med.umich.edu/pdf/guideline/om.pdf (accessed 2005 Jun 21).
3. Damoiseaux RAMJ. Antibiotic treatment for acute otitis media: time to think again [commentary]. *CMAJ* 2005;172(5):657-8.

Competing interests: None declared.

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HRT and antidepressants

Roger McIntyre and associates[1] discuss reciprocal relationships between hormone replacement therapy (HRT) and antidepressant treatment. Although some women experience significant mood changes related to changes in estrogen levels at menopause, I believe there is another obvious explanation for the increase in prescriptions for selective serotonin reuptake inhibitors (SSRIs) after publication of the Women's Health Initiative (WHI) trial.[2]

Hot flashes occur in 65%–75% of women during natural or induced menopause.[3] Many women discontinued their hormone therapy because of the WHI results but continued to experience significant symptoms and sought medicinal help from their physicians. The only medications with scientific proof of efficacy, other than estrogen and progestins, are SSRIs, clonidine and, more recently, gabapentin.[3–7]

As demonstrated by Loprinzi and colleagues,[7] breast cancer patients with depression reported a reduction in hot flashes when taking SSRIs. Subsequently, other SSRIs were shown to have similar beneficial effects. However, SSRIs are much less effective in this regard than HRT (which is more than 85% effective).[3]

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References

1. McIntyre RS, Konarski JZ, Grigoriadis S, Fan NC, Mancini DA, Fulton KA, et al. Hormone replacement therapy and antidepressant prescription patterns: a reciprocal relationship [editorial]. *CMAJ* 2005;172(1):57-9.
2. Rossouw JAE, Anderson GL, Prentice RL, LaCroix AZ, Kooperberg C, Stefanick ML, et al. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. *JAMA* 2002;288:321-33.
3. North American Menopause Society. Treatment of menopause-associated vasomotor symptoms: position statement of the North American Menopause Society. *Menopause* 2004;11:11-33.
4. Evans M, Pritts E, Vittinghoff E, McClish K, Morgan KS, Jaffe RB. Management of postmenopausal hot flushes with venlafaxine hydrochloride: a randomized, controlled trial. *Obstet Gynecol* 2005;105(1):161-6.
5. Loprinzi CL, Sloan JS, Perez EA, Quella SK, Stella PJ, Mailliard JA, et al. Phase III evaluation of fluoxetine for treatment of hot flashes. *J Clin Oncol* 2002;20:1578-83.
6. Stearns V, Beebe KL, Iyengar M, Dube E. Paroxetine controlled release in the treatment of menopausal hot flashes: a randomized controlled trial. *JAMA* 2003;289:2827-34.
7. Loprinzi CL, Kugler JW, Sloan JA, Mailliard JA, LaVasseur BI, Barton DL, et al. Venlafaxine in management of hot flashes in survivors of breast cancer: a randomized controlled trial. *Lancet* 2000;356:2059-63.

Competing interests: Dr. Wolfman has received an honorarium from Wyeth for speaking to physicians about issues to do with menopause.

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I was dismayed when I read the commentary by Roger McIntyre and associates[1] regarding antidepressants and menopause. The final paragraph, advising practitioners to "familiarize themselves with the beneficial effects of serotonergic antidepressants on climacteric symptoms" is essentially a push to prescribe these medications for symptomatic menopausal women.

This suggestion is backed up by one reference, a position statement of the North American Menopause Society.[2] This article is a literature review (I am unaware of any properly conducted clinical studies on this subject) which in fact recommends other interventions (e.g., lifestyle and dietary supplements) as first-line therapy, with SSRIs coming in later, together with progesterone and gabapentin.

Overall, I believe this commentary is misleading. It encourages physicians to prescribe a potent class of medications for climacteric symptoms without the benefit of any careful clinical studies.

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References

1. McIntyre RS, Konarski JZ, Grigoriadis S, Fan NC, Mancini DA, Fulton KA, et al. Hormone replacement therapy and antidepressant prescription patterns: a reciprocal relationship [editorial]. *CMAJ* 2005;172(1):57-9.
2. North American Menopause Society. Treatment

of menopause-associated vasomotor symptoms: position statement of the North American Menopause Society. *Menopause* 2004;11(1):11-33.

Competing interests: None declared.

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We received no response from Dr. McIntyre and colleagues to our invitation to reply to these letters.

Standards for pharmaceutical advertising in Canada

Richelle Cooper and David Schriger[1] report their analysis of original research cited in pharmaceutical advertisements appearing in medical journals published in the United States. However, the standards for advertisements in US medical journals differ from those for Canadian ones. Almost all of the advertisements appearing in the latter are reviewed and precleared by the Pharmaceutical Advertising Advisory Board (PAAB). The standards of the PAAB "Code of Advertising Acceptance" are publicly available.[2]

Advertising reviewed and authorized by the PAAB must meet the following criteria:

- The advertisement must contain a list of references for medical claims. These references are analyzed by PAAB reviewers, who have received training in critical appraisal from expert academics teaching at leading Canadian medical schools.
- All references used to support claims must be provided to the PAAB during the review process, which provides assurance that they exist and are obtainable.
- All references used must be available to health care professionals on request.
- The advertisement must not contain data-on-file references unless such studies were part of a New Drug Submission reviewed by Health Canada.

Although not prohibited by the PAAB code, the fact that the majority of original research cited to substantiate claims is in some way affiliated with the product's manufacturer is considered during the review process. The code requires that "Clinical/therapeutic claims must be based on published, well-controlled and/or well-designed studies with clinical and statistical significance clearly indicated. Publication in peer-reviewed journals is usually a good criterion for establishing scientific rigor."[2] This exceeds the standard for accredited continuing education events.

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References

1. Cooper RJ, Schriger DL. The availability of references and the sponsorship of original research cited in pharmaceutical advertisements. *CMAJ* 2005;172(4):487-91.
2. Code of advertising acceptance. Pickering (ON): Pharmaceutical Advertising Advisory Board; 2005. Available: www.paab.ca/index_en.html (accessed 2005 Apr 26).

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[The authors respond:]

We thank Ray Chepesiuk for identifying important differences between Canada and the United States in the regulation of pharmaceutical advertisements and applaud the Canadian effort. Canadian regulations with regard to prerelease review of advertisements are unquestionably more stringent. We are concerned, however, that in neither country is the regulatory effort adequate to ensure that all of the relevant information is available to those making decisions about the effectiveness and cost-effectiveness of medications.[1] Although the pharmaceutical industry's recent commitment[2] to make all clinically relevant trial data available on an industry-sponsored Web site (www.clinicalstudyresults.org) may help in this regard, at present much relevant material remains unpublished, and peer-reviewed publications often fail to tell the whole story.[3] Trial registry with electronic publication of research protocols before inception of each trial[4,5] and Web posting of complete data sets upon publication of the findings are 2 measures that could promote greater comprehensiveness and honesty in the reporting of trials.

Even if these measures are enacted, clinicians should remember that advertising exists to create a demand for a product and that claims made in advertisements may or may not be true. It is therefore imperative that all relevant information is on the table before clinicians and patients make decisions about the utility of medications. Despite increasing regulation, more remains to be done, and "caveat emptor" still applies.

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References

1. Cooper RJ, Schriger DL. The availability of references and the sponsorship of original research cited in pharmaceutical advertisements. *CMAJ* 2005;172(4):487-91.
2. New database provides doctors and patients unprecedented access to clinical study information for marketed medicines [press release]. Washington: Pharmaceutical Research and Manufacturers Association; 2004 Sept 7. Available: www.phrma.org/mediaroom/press/releases/07.09.2004.1063.cfm (accessed 2005 May 18).
3. Smith R. Medical journals are an extension of the marketing arm of pharmaceutical companies. *PLoS Med* 2005;2(5):e138.
4. De Angelis C, Drazen JM, Frizelle FA, Haug C, Hoey J, Horton R, et al; International Committee of Medical Journal Editors. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. *CMAJ* 2004;171(6):606-7.
5. De Angelis CD, Drazen JM, Frizelle FA, Haug C, Hoey J, Horton R, et al. Is this clinical trial fully registered? A statement from the International Committee of Medical Journal Editors. *CMAJ* 2005;172(13):1700-2.

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Time-dependent analysis in CHF follow-up

Justin Ezekowitz and colleagues[1] have concluded that patients with congestive heart failure who are followed by specialists and family physicians (FPs) experience better survival than patients who are followed by FPs alone; however, their analysis is not internally consistent.

In the Methods section they state, quite appropriately, that "[a] time-dependent analysis is essential when examining the effect of physician follow-up because patients' outcomes can determine their