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[Three of the authors respond:]

We thank Dr. J. Ellen Anderson for her comments.

As part of the HAMD-7 primary-care validation initiative, family physicians were asked to evaluate a depressed patient with several psychometric tools including the Hamilton Depression Rating Scale 7-item (HAMD-7), HAMD-17, Montgomery Asberg Depression Rating Scale (MADRS) and Clinical Global Impression (CGI). The interrater reliability (κ_w) was determined for each scale and was determined to be: HAMD-7 0.83, HAMD-17 0.98, MADRS 0.89, CGI-S 0.80, respectively.[1]

These data are in keeping with the view that there is an overall high level of agreement amongst family physicians on more global measures of depression, as well, as with the briefer tool (i.e., the HAMD-7).

We would agree that contextual issues always need to be considered in evaluating a depressed patient, nevertheless a consistently applied validated metric is a preferred tool. The HAMD-7 has been validated and a remission cut-score has been operationalized (HAMD-7 total score < 3) in both primary and tertiary care settings.[2] In a subsequent analysis, we have determined that the depressive symptoms most frequently endorsed by depressed persons in primary care are highly similar to patients in the tertiary care setting.

We agree that the PHQ-9 is a useful tool to track symptomatic progress in patients who are treated for depression.[3] We agree that suicide should be a constituent item in any valid depression metric (both the PHQ-9 and the HAMD-7 include a suicide item). Any patient reporting a score greater than zero (i.e., suicidal ideation/plan/attempt) on the suicide item of the HAMD-7 should be further probed.

We feel that the evaluation of quality of life and function is essential when evaluating antidepressant effectiveness. When patients are asked to report what remission means to them, the presence of positive mental health, such as optimism and self-confidence, and a return to one's usual self and functioning, were just as, if not more, important than depressive symptom abatement.[4] We are of the opinion that exploration of these domains should be part of the routine evaluation of the patient. This would be similar to managing the hypertensive patient in which blood pressure quantification is supplemented with questions regarding patient's subjective well-being, activity level and overall functioning.

Measurement-based care has been shown to enhance patient outcome in the management of depression in real-world settings.[5] We would encourage the routine use of validated symptom measurement tools (e.g., HAMD-7, PHQ-9) that have been validated in multiple settings.

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Ginseng enhances the effectiveness of DHEA

I appreciated the RCT on the efficacy of ginseng for preventing upper respiratory tract infections.[1] I suggest cortisol evolved as the natural antagonist of dehydroepiandrosterone (DHEA) activity and is the basis of the "fight or flight mechanism." This is derived from my hypothesis that the major pathway of adrenal hormone production is the "dehydroepiandrosterone pathway," which consists of DHEA and cortisol. Increased cortisol may affect many tissues.[2] Ginseng reduces cortisol production.[3] By reducing the amount of cortisol, and hence the cortisol to DHEA ratio, ginseng increases the relative effectiveness of available DHEA. DHEA is known to exert protection from many infectious agents, including viruses. I suggest ginseng lowers the incidence of upper respiratory tract infections because it decreases the cortisol to DHEA ratio.

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Personal conviction: What role should it play?

I enjoyed the humour in the article by Barbara W. very much.[1] I agree that it is unfair to humiliate people, and that humiliation is particularly reprehensible when people are in vulnerable situations. I have, however, a question about the implication that the pharmacy assistant was being unprofessional because he let his personal conviction affect the provision of care.

I would like to assume for the sake of argument that his personal conviction was that Plan B is unethical because it induces abortion and he is of the opinion that abortion ends a person's life. By providing Plan B he would be doing something that he genuinely believes is in the best interest of neither his adult client nor her embryo. Wouldn't it be unprofessional to ignore this conviction and provide the drug anyway? What should a professional do when he is asked to do something by a client that he genuinely believes is not in the client's best interest? What would a lawyer do?

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REFERENCE

1. W.B. Counter attack. *CMAJ* 2006;174(2):211-2.

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Corrections

There was a clerical error in the date of death of Dr. Brian Williams as listed in a recent issue.[1] Dr. Williams died on Nov. 17, 2005, not Nov. 18, 2005, as indicated. We apologize for the error.

REFERENCE

1. Deaths. *CMAJ* 2006;174(3):323.

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An error was made in the news article, "SSRI ads questioned."[1] Dr. Wayne Goodman, Chair of the US Food and Drug Administration Psychopharmacologic Drugs Advisory Committee does not support prohibiting advertisements making certain claims for selective serotonin reuptake inhibitors.

REFERENCE

1. Meek C. SSRI ads questioned. *CMAJ* 2006;174 (6):754.

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