Pet peeves

My pet peeves: paper tissues in the laundry, toilet seats left up, cars that follow too closely. Dr. Ursus's pet peeve: "patients who ask to be notified of their test results."[1]

I can understand if Dr. Ursus wants to lament the cost and inconvenience of calling patients with test results (or suggest solutions to the problem). But physicians who consider patients' health — both physical and mental — a pet peeve need to re-evaluate why they are in the medical profession.

Christina M. Penner
University of Manitoba
Winnipeg, Man.

REFERENCE

1. Query. *CMAJ* 2006;174(9):1376.

DOI:10.1503/cmaj.1060109

Merits of psychotherapies

I wish to highlight 2 issues regarding the article on the use of antidepressants in children and adolescents.[1]

First, the majority of the main measures used in the 16 studies failed to support the drug over placebo. Ten of these studies were unpublished (all of which were industry-sponsored) and, of these, only 1 study showed any significant benefit over controls. Of the 6 published studies, only 4 showed any significant benefit on main measures. On its own, this suggests a publication bias where positive studies were over 6.6 times more likely to be published than negative studies. Therefore, it is premature to conclude that these drugs are superior to placebo controls. Physicians should use great caution in making decisions based on data from published studies alone.[2]

Second, brief psychotherapies were not highlighted as a reasonable alternative. These treatments are non-toxic and cost-effective, and preferred by patients.[3] On their own, they are more effective than wait-list or minimal treatment controls — the Treatment for Adolescents With Depression Study (TADS), cited by the authors[1] is an exception.[4]

Given the side effects and controversies surrounding antidepressants in children, brief psychotherapies should be the first-line single treatment.[4] Informed consent should include telling parents that brief psychotherapies are reasonable, safe, effective alternatives to drugs. Brief psychotherapies may improve overall coping skills and prevent relapses in children. If we lack resources to provide these treatments, parents can use this evidence to lobby government and health care providers to make sure these treatments are made available.

Allan Abbass
Director of Education
Department of Psychiatry
Dalhousie University
Halifax, NS

REFERENCES

1. Cheung AH, Emslie GJ, Mayes TL. The use of antidepressants to treat depression in children and adolescents. *CMAJ* 2006;174(2):193-200.
2. Melander H, Ahlqvist-Rastad J, Meijer G, et al. Evidence b(i)ased medicine — selective reporting from studies sponsored by pharmaceutical industry: review of studies in new drug applications *BMJ* 2003;326(7400):1171-3.
3. Abbass A, Gardner D. Informed decision making with depressed patients: medications and psychotherapy options. *Am Fam Physician* 2004;69 (9):2071-2, 2074.
4. Ryan ND. Treatment of depression in children and adolescents. *Lancet* 2005;366(9498):1694.

Competing interests: None declared.

DOI:10.1503/cmaj.1060048

Privacy concerns in preventing fraudulent publication

I understand the need for scientific journals to take every reasonable step to prevent the publication of flawed or fraudulent research,[1] but, as Ontario's privacy commissioner, I have serious concerns about the proposed solution of publishing all of the data on which research findings are based.

The *CMAJ* editorialists state that the ethical and legal obstacles in doing so, such as "anonymizing" the data, can be overcome. However, rendering a data set anonymous is not a trivial matter. My experience in dealing with privacy issues in the context of research indicates little consensus within the research community as to what variables need to be stripped from a data set to render it truly anonymous. If anonymization is not done in an extremely conservative manner, the data set could be used alone or linked with other data to re-identify individuals. There is also the risk of re-identification of individuals through the publication of small sets of data.

It is my understanding that most researchers treat all data sets — anonymized or not — as confidential personal information, a highly desirable practice. Further, to the extent that anonymous data sets may be used to re-identify individuals, their publication may be a violation of Ontario's Personal Health Information Protection Act (PHIPA) (and possibly other health privacy statutes in other provinces) and/or the requirements imposed by research ethics boards.

Even if data sets could be truly anonymized, it is not clear that their publication would be useful for validating research, as suggested in the editorial.[1] In many cases, there would be insufficient information in a stripped-down data set to replicate findings or conduct further analyses.

The publication of data sets would