

Antidepressants and spontaneous abortion

On the cover of the July 13, 2010 issue of *CMAJ* was the heading, "Use of antidepressants in pregnancy increases the risk of spontaneous abortion." The findings in the related research article by Nakhai-Pour and colleagues are based solely on prescription drugs.¹ No estimate was done of actual compliance with the medications. If a woman was aware that she was pregnant, the likelihood of her taking the medication might be lower. Patients sometimes fill a prescription but then decide against taking it.

Medical contact for antidepressant therapy might be associated with pregnancy testing, making women more aware that vaginal bleeding might be a sign of spontaneous abortion.

What can be said is that filling a prescription for an antidepressant is associated with an increase in clinically detected spontaneous abortions.

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We thank Lint for his comment on our article.¹ Indeed, our 68% increase in the risk of spontaneous abortion with gestational use of antidepressants was based on prescriptions filled and not actual medication intake. The potential limitations associated with this were clearly stated in our article. We also highlighted that there is enough evidence-based research showing that the majority of pregnant women having a prescription filled will take at least one dose. Hence, our main definition of exposure categorized women dichotomously as having taken at least one dose. Our main finding replicates the results of a study by Einarson and colleagues,² who showed that, based on women's reports of actual medication intake, antidepressant use

during gestation increased the risk of spontaneous abortion by 68%.

In this instance, actual antidepressant intake and antidepressant use defined by prescriptions filled gave concordant findings. The novelty of our study was its large sample size, which also enabled the study of antidepressant types and dosages.

Finally, there is no evidence showing that medical contact for antidepressant therapy increases the rate of pregnancy detection.

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"Hari": not embedded needles

Park and Shim described a female patient who had countless acupuncture needles left in her body, especially around paraspinal muscles.¹ They stated that "this subtype of acupuncture known as Hari involves the permanent placement of fine needles into the subcutaneous tissue," but this is not correct.

The Japanese word Hari means sewing needle, acupuncture therapy or acupuncture needle. When we use this word to mean acupuncture therapy, it means acupuncture in general. Referring to a paper by Vassiou and colleagues,² Park and Shim explained that the retained needles are typically 1 mm in diameter, but this is also incorrect. The diameter of retained needles is the same as that of acupuncture needles usually used in Japan: between 0.14 and 0.20 mm.

In Japan, we usually use the word Maibotsu-Shin for embedding acupuncture needles, but this practice is

not performed anymore because it has caused many adverse events.³

As with the evaluation of efficacy in evidence-based medicine, the safety of acupuncture should be assessed through prospective surveys or controlled studies that show incidence, degree of severity and significance of differences with control groups. Recent large-scale prospective surveys in Germany involving about 200 000 patients show that serious adverse events of acupuncture are very uncommon,^{4,5} but some do occur. We continue to provide all those who perform acupuncture with updated information for safer practice.

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Routine peripubertal circumcision?

MacDonald deserves credit for shifting the debate on circumcision away from inconclusive quibbles about the balance of risks and benefits,¹ but it is not obvious that peripubertal boys are any more capable of giving consent than a baby. They lack maturity and sufficient knowledge; boys at 11 or 12 years of age are not considered competent to consent to sexual relations with others,

and even if they agree to have sex, the other party will be guilty of sexual assault. If they cannot consent to sexual relations, they are certainly not competent to consent to having a part of their penis excised.

The practice with respect to genital surgeries should be no less strict than the rules governing sexual activity. If circumcision provides some protection against sexually transmitted infections (a contentious point^{2,3}), the only logical age at which a male can legally consent to circumcision would be the same as that of consent for sexual purposes. If it is wrong to perform circumcision in infancy, it is equally wrong to perform it at any time before legal adulthood.

MacDonald's contention that circumcision at puberty provides "the opportunity for informed choice ... the boy can give assent" is contradicted by experience. Many tribal societies perform initiation rites on peripubertal boys and girls, sometimes involving circumcision, but the children have no more opportunity to decline the operation than to fly to the moon. If they object, they are subject to violent coercion; if they run away, they are ostracized. Circumcision of boys at around 9 to 11 years of age is usual in South Korea and the Philippines, where social expectation, peer pressure and the fact that boys are still children subject to parental discipline means that they have little chance of saying, "No thanks."^{4,5} Unless they can decline without prejudice to their future social status, there is no possibility of free choice.

The "medically important question" is not whether circumcision should be "routinely offered to young male adolescents rather than their baby brothers," but how we can find an effective way of giving boys some protection against genital cutting?

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Empathetic responses

I support what Buckman and colleagues have written about the teaching of empathy in medical schools.¹ I would add that it is the patient, not the doctor or faculty member, who evaluates whether a doctor shows empathy. Whereas we can always teach techniques to increase the awareness of doctors about the understandings, feelings and experiences of patients, the doctor does not determine whether he or she comes across as empathetic.

Mercer and Reynold's article included an "empathy scale," on which the patient grades the physician in 10 broad areas.² If the grade shows a lack of involvement, the physician may feel very vulnerable, especially with a difficult patient.

Few patients (and doctors) care about empathy if there is a speedy cure. The paradigmatic example is a surgeon: If you had to choose, would you want a good cutter or someone who understands you? Response by physicians to the patient's grading could provide additional scope for teaching empathy while acknowledging the need for empathetic interaction between physicians and teachers.

Empathy involves taking the time to know a patient as the patient understands him- or herself. And taking this time, as well as that required for understanding an often complex diagnosis, is in economic terms very inefficient and costly. Increasing the empathetic communication of physicians is not independent of revising other system health care values.

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Some letters have been abbreviated for print. See www.cmaj.ca for full versions.