Effect of fluoxetine and placebo on various end points

Intervention	Change in children's depression rating scale	Change in adolescent depression scale	Change in suicidal ideation questionnaire	Clinical global impressions improvement of 1 or 2 (%)
Fluoxetine	22.6	16.4	7.4	60.6
Placebo	19.4	14.6	9.2	34.8
Proportion of fluoxetine effect seen in placebo group	0.86	0.89	1.24	N/A

N/A=not applicable, categorical measure.

point, the children's depression rating scale (CDRS-R; P=0.10), but this was not mentioned in the abstract. This and the small or absent advantages of fluoxetine on other end points (table) and in other studies,[3] shows that fluoxetine, like all other antidepressants, is of doubtful clinical importance for children.

Adverse events and suicidal behaviour may be greater than the TADS paper says. Despite small numbers, more subjects leaving the study than reporting adverse effects, and the splitting of adverse events into multiple groups, significantly more psychiatric adverse events occurred in the fluoxetine group than the placebo group (χ^2 test (1 df), P=0.047). Despite small numbers and the exclusion of known suicidal behaviour, TADS found a trend to more suicidal behaviour (six attempts in the fluoxetine groups and one attempt in the non-fluoxetine groups), consistent with other trials of selective serotonin reuptake inhibitors (SSRIs). We are less reassured than the authors by the fact that no attempt was fatal. Suicide is a rare event so that a study the size of TADS should be expected to miss a significantly increased risk.

The data do not support the TADS authors' optimistic conclusions. The balance between benefit and harm of SSRI treatment for depression in childhood and adolescence has yet to be shown to be favourable.

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Competing interests: None declared.

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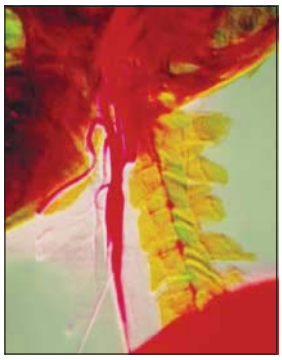
Surgery for carotid artery stenosis

Patients with critical stenoses should be admitted to stroke prevention units

EDITOR—While shopping in Florida, a man found a booth offering carotid duplex scans for a modest fee. He had a family history of cerebrovascular disease, so he decided to be scanned for peace of mind. Unfortunately, a critical internal carotid stenosis was found.

He returned to his hotel somewhat perturbed, only to be phoned by a vascular surgeon recommending urgent carotid endarterectomy before he flew home to the United Kingdom. He declined the offer, but underwent successful surgery some months later.


CNRI/SPL

Screening is not without drawbacks. The asymptomatic carotid surgery trial confirms that carefully selected patients benefit from surgery when operated upon by skilled teams.[1] The logic, which Toole finds compelling,[2] is that carotid screening should be considered.

Transcranial Doppler ultrasound can detect microemboli, which allows the efficacy of therapeutic interventions to be rapidly and non-invasively assessed. Controlling the rate of embolisation reduces the risk of an early postoperative stroke.[3] Controlling emboli and symptoms in patients with recurrent or crescendo transient ischaemic attacks by using Doppler directed drug therapy allows these high risk patients to undergo elective carotid surgery safely.[4]

Patients with focal neurological events need assessment within 24-48 hours. Those with critical carotid stenoses, symptoms and emboli should be admitted to a stroke prevention unit (similar to a coronary care unit). It would be jointly managed by vascular surgeons and stroke doctors, with high ratio of staff to patients. Rapid control of microemboli could be achieved, and since microemboli seem to be surrogate markers for future embolic events, some strokes will be prevented.

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Cut-off point is problematic in selecting patients for carotid surgery

EDITOR—Toole's voice is important in the controversial debate on carotid surgery.[1] However, in determining a cut-off point for selecting patients for endarterectomy, the different methods of measurement (local versus distal degree of stenosis) used by European and American surgery trials must be considered.[2]

A cut-off point of 60% stenosis refers to the asymptomatic carotid artery stenosis study (ACAS) and uses the American method of stenosis measurement[3]; that degree of stenosis corresponds to a 75% stenosis according to European criteria.[2] Therefore, to define a cut-off point of 60% stenosis in a European journal is misleading.

I agree with Toole that other indicators for selecting patients for carotid surgery should be considered; however, apart from the degree of stenosis, there are no evidence based criteria that allow medical or surgical treatment to be decided. So the degree of stenosis remains the main criterion; measurement should be performed by means of Doppler and duplex ultrasound evaluation.[4]

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1 Toole JF. Surgery for carotid artery stenosis. *BMJ* 2004;329:635-6. (25 September.)
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Author's reply

EDITOR—I am pleased that my editorial has evoked responses about the looming epidemic of stroke, often the result of carotid artery disease. We hope that all risk factors will be reduced by careful attention to good health habits including diet, smoking, blood pressure control, etc, and in selected cases, platelet anti-aggregants and statins.[1] For

patients who, despite control of risk factors, go on to develop severe, carotid bifurcation atherosclerosis, simple methods now exist to identify preclinical disease by using ultrasound and for delineation of transient ischaemic attack with a short questionnaire.[2] Auscultation for bruits is practical depending on the auscultatory technique and ambient noise. Identifying cases is of little benefit unless the opportunity to intervene exists in the healthcare system.

It would be foolhardy to make blanket or case specific recommendations for medical and surgical management. Moreover, screening has nothing to do with the treatment that might be provided, which should most often be reduction of risk factors. It must never be considered that the reason for screening is to identify people who might be subjected to an interventional procedure such as stent, balloon angioplasty, or endarterectomy. It is for this reason that I urge that non-procedure oriented physicians be firmly in charge of the screening and the recommendations that are made.

I am among those who suspect that the condition of the carotid artery is a marker for atherosclerosis in other organs, particularly the heart. If the easily accessible carotid artery could be used as the indicator for the other arteries, including the coronaries, abdominals, and cerebral circulation, this would be a big step forward. It may be premature to call for mass screening, but it is highly appropriate for individual doctors to use the technology now at hand for identification of cases and early intervention with long term follow up designed to reduce risk.

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Transparency and trust

Figure for ghost written articles was misquoted

Editor—Editor's choice in the issue of 23 October on transparency and trust seems to perpetuate a misleading press citation of my testimony to a House of Commons Select Committee last month.[1] The original statement, supported by the transcript, was that 50% of the articles dealing with therapeutics were ghost written, not 50% of all articles.[2 3]

I, like most readers, almost instinctively shrink from a claim that anything like 50% of the articles, even those on therapeutics alone, are ghost written in journals such as the *BMJ*, *New England Journal of Medicine*, *JAMA*, and the *Lancet*. But equally instinctively, most readers if asked to estimate how many of the key articles on their drugs, and this means articles in major journals, pharmaceutical companies are likely to have had a determining role in writing, would probably come up with figures close to 100%. If the question is in what proportion of articles on therapeutics in major journals do the apparent academics hold the raw data and are able to share that data if needed, the answer in many estimates will not be much greater than 0%.

Abbasi usefully brings out a point made in the select committee's meeting, that the key problem with ghost writing is not the medical writing itself but the issue of transparency. When there is reason to believe that the articles that result from the ghost writing process do not offer a fair representation of the underlying data there is a problem. Otherwise ghost writing poses much less of a problem.

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Competing interests: DH is a speaker, trialist, or consultant for all major pharmaceutical companies and an expert witness in medicolegal actions involving selective serotonin reuptake inhibitors.

1 Abbasi K. Editor's choice. Transparency and trust. *BMJ* 2004;329:0-g. (23 October.)
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In defence of medical writers

Editor—If ghost writing is defined as what happens when the identity of a writer is concealed, then Abbasi's statement, "We know that ghost writing happens, and the identity and the motivations of the ghost writer are not revealed" is self evidently true, albeit not very informative.[1] However, many people understand medical ghost writing to mean that a professional medical writer, whose name does not appear on the author list, wrote the paper. When this happens, the identity of the writer is sometimes not revealed, but it often is, usually in the acknowledgments section. It is therefore misleading to state that the identity of the ghost writer is not revealed as though this were a universal truth.

Kmietowicz's news article also misleads by saying that distinguished authors put their names to papers without ever seeing the raw data.[2] This may be true but is hardly the whole story. What exactly are you supposed to do with thousands upon thousands of laboratory results, for example? Data from clinical studies can be interpreted only once they have been processed into summary tables and graphs: a job that is more appropriately done by a statistician than a clinician. In my experience of writing papers on behalf of investigators, the named authors always have access to the summary tables and graphs, which is far more important than access to the raw data.

I agree, however, that high ethical standards must be maintained when professional medical writers draft papers on behalf of named authors, and that transparency is an essential part of this. One set of recently published guidelines seeks to ensure good practice in this context,[3] and the European Medical Writers Association is currently preparing guidelines that will further define the ethical responsibilities of professional medical writers.

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Competing interests: AJ's company provides medical writing services. He is also president of the European Medical Writers Association.

1 Abbasi K. Editor's choice. Transparency and trust. *BMJ* 2004;329:0-g. (23 October.)
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Clear definition of ghost writing would be helpful

Editor—The requirement that all authors have the idea, do all the work, get the data, analyse the data, and write the paper may be perfectly applicable to fundamental research, perhaps, or small clinical trials. In large studies it is not applicable: we are doing a 40 000 patient study of non-steroidal anti-inflammatory drugs and COX-2 inhibitors, requested by the regulatory authorities, financed by pharmaceutical companies, driven by an independent scientific committee. Fifty people, including half a dozen statisticians, work in this study, which will generate about a hundred million bits of data. Papers will be written by medical writers under the surveillance and final approval of the scientific committee. Is this ghost writing?

May I hire a professional writer to write papers students did not or could not write, and I don't have the time to? Should these data lie ignored? Should that writer, who was not involved in the initial conception or in data collection or its analysis be an author? If not, is it ghost writing?

There is an infinity of variations between the lone searcher who does everything, and the key opinion leader who does nothing but sign.

Abbasi's simple statement that 50% of all publications are ghostwritten is misleading and derogatory,[1] indicating a misunderstanding of the complexities of modern studies. It could too easily be picked up by politicians (who we all know write their speeches themselves) and others for some easy doctor bashing. There may be some