Antidepressant drugs 'work', but they are not clinically effective

Sir

One 'key point' of McAllister-Williams' editorial (vol 69(5), 2008, p. 246) on our meta-analysis of antidepressant trials (Kirsch et al, 2008) was that 'randomized controlled trials are tools to assess whether or not drugs work'. Another key point was that 'randomized controlled trials are poor ways of assessing clinical effectiveness of drugs'. I wonder if other readers were as puzzled by this as I was. When we say a drug works, don't we mean that it is clinically effective?

Reading the editorial, we learn that 'work' and 'clinical effectiveness' are not equivalent. McAllister-Williams uses work to mean statistical difference from placebo. Clinical significance means the drug–placebo difference is large enough to make a meaningful difference in someone's life. The two-point difference we found on the Hamilton scale will be statistically significant when the results of many trials are analysed together, but it is not clinically meaningful. It can be achieved, for example, by no longer waking up early, while still feeling as depressed and suicidal as before. Clinical trials show that antidepressants work statistically, but the difference from placebo is not clinically significant, even in most of the studies on patients whose depression was 'very severe' as defined by the National Institute for Clinical Excellence (2004).

Although the 'effect' of antidepressants is not great, the 'response' (i.e. the change from baseline) to them is. But the response to placebo is almost as great. McAllister-Williams maintains that this is unimportant in deciding whether to prescribe antidepressants, because one cannot give patients placebos. However, treatment alternatives that are not placebos (e.g. psychotherapy, exercise, self-help books) can evoke the placebo response (and perhaps more) without the side effects produced by drugs. Clinical trial data suggest that these less problematic alternatives might be tried first, with drugs reserved for cases where they do not work.

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Novel technique of securing spectacles while operating

Sir,

Surgeons often wear spectacles and loupes while operating to improve their vision. These may also prevent contamination of the eyes (Bell and Clement, 1991; Davies and Harrison, 1991) and transmission of viruses such as human immunodeficiency virus or hepatitis B virus (Sharma et al, 2003). Although spectacles give some protection, goggles and face shields are far better (Prior et al, 1993), but may not always be available, particularly in developing countries (Chong et al, 2007). A concern is spectacles falling off into the wound.

Traditionally a thread is used to connect the arms of the spectacle around the head, keeping the spectacles in place (*Figure 1*). However, this can become contaminated and dirty from repeated use over time, especially if it is not regularly washed or changed.

Using sticky tape to stick the metal bridge of the spectacles to the forehead and keep them in position is another option (*Figure 2*) but it can mark the frame and the surgeon may develop an allergy to the tape.

Figure 1. Traditional method of securing spectacles.

The authors' new technique involves looping the upper ties of the face mask around the spectacle arms and tying them around the back of the surgeon's head (*Figure 3*). This will keep the spectacles safe and secure.

As far as we know, this method has not been published. It is simple and does not require any material other than the face mask which is readily available. Allergy to face mask material has not been reported. Although the mask can keep glasses secure while operating, one should take extra precautions while undoing the face mask. The authors recommend this as a safe way of keep spectacles in place while operating.

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Figure 2. Securing spectacles with sticky tape attaching the middle piece of the frame to the forehead.

Figure 3. Novel method of securing spectacles using the upper ties of a face mask.