Prostate-specific antigen screening

I read Dr Robert Burn's letter on prostate-specific antigen screening[1] with personal interest, having recently been declared "cured" [of prostate cancer] 6 years after brachytherapy (radioactive iodine) treatment.

Given that my father had incidental prostate cancer later in his life, and considering myself to be at some increased risk, I enrolled in the multicentre SELECT (Selenium and Vitamin E Cancer Prevention Trial) study some 10 years ago. The purpose of the study was to test, in a double-blinded trial, the hypothesis that selenium or vitamin E might decrease the incidence of prostate cancer. (The study was abandoned when it was found that the incidence of type 2 diabetes increased with one of the drugs and the incidence of prostate cancer slightly increased with the other. Incidentally, on inquiry I discovered that I was in the double-placebo group.)

I further reasoned that if I did have the disease, being part of a study would result in fast-tracking to treatment. This proved to be the case when a modest increase in prostate-specific antigen screening tests year to year (although still less than 4) led to a biopsy and the discovery that I had the disease in both lobes. What to do? I was offered, of course, the full range of treatment options and considered myself to be a "poster boy" for brachytherapy, which seemed to me the best choice, with good outcomes and fewer side effects. On subsequent inquiry, I was informed by a study nurse that more than 100 cases had been picked up in the study (of more than 1100 participants) and that I was the only one who had opted for brachytherapy.

I must confess that the idea of "sitting on a touch of cancer" had little appeal to me as an option. My procedure was uneventful and "went very well," in the words of my radiotherapist who performed the procedure. Side effects have been of the nuisance variety, with no performance issues, at least for a few years. (I now use Viagra for enhancement purposes, likely age-related I tell myself—I'm 73.)

Having been declared cured and now back in the care of my family physician for routine follow-up, I often wonder if I am among those thought by some to have been overtreated for minimal disease. We'll never know. But I am pleased with the course of action I took and to call myself a survivor.

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Competing interests
None declared

Reference
1. Burn R. The tragic trajectory [Letters]. *Can Fam Physician* 2011;57:655-7.

Difficult balance being gatekeepers

I read Dr Burns' letter, "The tragic trajectory,"[1] published in the June issue of *Canadian Family Physician* with interest. It is difficult to keep the balance and not allow the tail to wag the dog. Who has more medical experience and knowledge between patient and physician? It takes courage to draw the line—and to hold the line—at the best evidence. It is not necessary to do a test because the patient insists, especially when he or she only has emotional reasons to request it and especially when the patient's unique circumstances scream to us that the requested test or intervention is not indicated!

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Competing interests
None declared

Reference
1. Burn R. The tragic trajectory [Letters]. *Can Fam Physician* 2011;57:655-7.

Women with depression should be offered folic acid

We disagree with Nahas and Sheikh's conclusion that that there is insufficient evidence to recommend folate for major depressive disorder (MDD).[1] Our review of the same studies cited in their review of alternative medicines for depression leads us to the opposite conclusion and reveals misinterpretations of the data. We outline these studies here so that readers can draw their own conclusions.

In a 10-week randomized, blinded trial, Coppen and Bailey measured the effect of folate when combined with fluoxetine for the treatment of major depression (N=127).[2] The relatively unimpressive average improvement, noted by Nahas and Sheikh, is shown to be the result of a sex-specific response variable. Based on intention to treat and per protocol analyses, response and remission rates as well as end-point depression scores in the folate plus fluoxetine group were shown to be clinically superior for women but not men (**Table 1**).[2] Only around 3 to 4 women need to be treated with folic acid for 1 to achieve treatment response or remission. This highly clinically meaningful result has also been overlooked in recent depression guidelines.[3,4] It