goes beyond it. I believe the above statements are important to reflect upon to help guide us forward. This will allow us to continue the strong tradition of family medicine in Canada that Dr Ian McWhinney and others have envisioned.

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Competing interests
None declared

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Benefits of CBT for OCD in pregnancy

We read with great interest the article by Namouz-Haddad and Nulman,[1] which discussed treatment options for obsessive-compulsive disorder (OCD) in pregnancy and puerperium. This issue is of critical importance given its prevalence, the level of impairment caused by OCD, and the need for clinicians to consider risks that occur when treating this population that would otherwise be absent in nongravid patients. We appreciate their informative and concise review of the literature and the authors' resolve to present available treatment options. Within the article's many strengths, there are 3 concerns that we would like to address.

First, the article lacks relative equipoise with cognitive-behavioural therapy (CBT) in relation to selective serotonin reuptake inhibitors (SSRIs). The authors supplied an excellent discussion of pharmacologic treatment; however, they provided only a 1-sentence rationale in favour of CBT for OCD. Indeed, CBT with exposure and response prevention has been shown to display more robust treatment outcomes than pharmacotherapy using serotonin reuptake inhibitors (SRIs)[2,3] and has been recommended as the front-line treatment option for nongravid patients with OCD.[4] Preliminary data support CBT for OCD in pregnancy and puerperium as monotherapy[5] and in combination with an SRI.[6] In addition to the aforementioned efficacy of treatment, CBT lacks the negative side effect profile discussed by Namouz-Haddad and Nulman that is associated with SSRIs.[1]

Second, patient considerations must be taken into account when prescribing a treatment plan.[4] This is even more prudent when working with vulnerable populations such as pregnant and postpartum women. As discussed by Namouz-Haddad and Nulman,[1] there is a lack of clinical agreement regarding the safety of exposing an infant to SSRIs through breast milk. Data suggest that CBT is a well regarded treatment approach relative to SSRI monotherapy among nongravid individuals with OCD.[7] Given this, a behavioural approach that lacks these risks should always be considered in the initial treatment plan.

Third, although efficacious, treatment with SRIs rarely produces remission. In fact, using SRIs alone, only approximately 40% to 60% of individuals achieve a clinically meaningful treatment response.[8] There are additional concerns to consider such as the substantial rates of relapse after medication is discontinued.[9] This leaves the clinician at a loss for what to do next. There is clear support for providing CBT in an augmentation approach[10,11]; however, as discussed above, CBT alone should always be considered as an

initial intervention given its efficacy, safety, and patient acceptability. Other approaches, such as antipsychotic augmentation, have concerning side effect profiles[12] and have not consistently demonstrated superiority relative to placebo in methodologically rigorous controlled trials.[10]

We are grateful to Namouz-Haddad and Nulman[1] for providing an excellent review of OCD in pregnancy and puerperium and treatment options for this population. Disseminating accurate and reliable treatment information to clinicians is of critical importance, as safe and effective treatment for this population is necessary for the well-being of both the mothers and newborns. In an effort to present well-rounded treatment suggestions, we suggest a more thorough and balanced explanation of CBT and the inherent benefits of this empirically supported behavioural treatment.

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Competing interests
None declared

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Correction

In the article "Imaging appropriateness criteria. Why Canadian family physicians should care," published in the March 2014 issue of *Canadian Family Physician*,[1] the correspondence information was incorrect. It should have read as follows:

Dr Benjamin Fine, Department of Medical Imaging, Faculty of Medicine, University of Toronto, 263 McCaul St, 4th Floor, Toronto, ON M5T 1W7; e-mail **ben.fine@utoronto.ca**

Reference
1. Fine B, Dhanoa D. Imaging appropriateness criteria. Why Canadian family physicians should care. *Can Fam Physician* 2014;60:217-8 (Eng), e144-6 (Fr).

Correction

Dans l'article intitulé en français «Critères de pertinence de l'imagerie. Pourquoi les médecins canadiens devraient s'en soucier» et, en anglais, «Imaging appropriateness criteria. Why Canadian family physicians should care», publié dans le numéro de mars 2014 du *Médecin de famille canadien*[1], les coordonnées pour la correspondance étaient incorrectes et auraient dû se lire comme suit :

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Reference
1. Fine B, Dhanoa D. Imaging appropriateness criteria. Why Canadian family physicians should care. *Can Fam Physician* 2014;60:217-8 (ang), e144-6 (Fr).