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Comparative Trial of a New Antidepressant

SIR: There are 16 tricyclic and related antidepressants currently on the market. It seems likely that most psychiatrists use only a small number of them routinely. Before any more new antidepressants are added to this list, how insistent should we be in requiring that standardised methodologies be employed when testing their efficacy?

Levine *et al* (*Journal*, May 1987, **150**, 653–655) showed that fluoxetine was as effective an antidepressant as imipramine. However, their study did not include a placebo control to establish the relative efficacy of both of these drugs. The reason for this not uncommon omission is that imipramine is considered to be of proven efficacy and, therefore, a reliable benchmark against which new antidepressants can be measured. How justified is this assumption?

In two extensive reviews of the literature, tricyclic antidepressants were not found to be superior to placebo in 35% (Morris & Beck, 1974) and 41% (Thomson, 1982) of studies. Swallowing an inert placebo leads to a significant improvement in between 30% (Morris & Beck, 1974) and 50% (Medical Research Council, 1965) of those suffering from depression. Mild side-effects (which fluoxetine possesses) are associated with greater drug success, while zero or severe side-effects are associated with less success (Brune *et al*, 1962). The advantage of tricyclic antidepressants over placebo is significantly less when an active (atropine) placebo is used instead of an inert substance (Thomson, 1982). Thirty per cent of depressed patients do not respond to tricyclic antidepressants (Medical Research Council, 1965): in the Levine *et al* study this figure was approximately 50%.

Thus the universal and invariable efficacy of tricyclic antidepressants has yet to be demonstrated. Therefore, imipramine and other 'standard' antidepressants should not be used as the sole agent in comparative studies. Levine *et al* did not use a placebo control, so we cannot be sure whether the improvement in depressive symptoms was due to a specific psychotropic, or an active placebo, effect.

JOHN DUNN

St Thomas' Hospital
London SE1

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Comparative Hospital Survey of Psychotropic Drug Prescribing

SIR: Muijen & Silverstone (*Journal*, April 1987, **150**, 501–504) showed that the hospital (hospital A) with the lowest prevalence of polypharmacy was the only one with an associated psychopharmacology unit. We have compared the authors' results with our acute in-patient population. Our data is obtained from a unit in our hospital, the population of which can be compared to that of the authors' hospital C. Ours is a teaching hospital, but has no association with any psychopharmacology unit.

Seventy-eight patients admitted in the past year were included in the study. All psychotropic drugs given on the seventh day of admission were recorded from case records; we presumed that a final diagnosis was reached and medication was started by one week after admission. The rest of our methodology is similar to that of the authors' study.

The results showed that more than one psychotropic drug was given to 49 patients (63%). This figure is close to the authors' figure for hospital A. More than two drugs were given to 23 patients (29%) and more than three drugs were given to 8 patients (10%). One patient received no drugs, one drug was given to 23 patients (29%), two drugs were given to 28 patients (36%) and three drugs were given to 18 patients (23%). Benzodiazepines were given to 22 patients (28%). More than one antipsychotic drug was given to 21 patients (27%), whereas anti-parkinsonian drugs were given to 17 patients (22%). The last two figures are lower than the authors'

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