Reply

DEAR SIRS

We read with interest the above letter by Dr Palin on the use of selective serotonin reuptake inhibitors.

He seems to be surprised that a significant number of his profession still "believe" in the use of tricyclic antidepressants. "Belief" usually comes from working with a particular group of drugs over a long period and results from a knowledge of their therapeutic efficacy as well as their potential dangers. It is to be remembered that until recently these drugs were the yardstick against which new drugs competed in clinical trials to establish their therapeutic status. The CSM would not have licensed the SSRIs unless they had been shown to have the same therapeutic benefits as those of the tricyclics.

Our article attempted to give a broad and balanced view of the introduction of the SSRIs. There are, of course, pharmacological arguments, not presented in this article, for the continued prescription of the tricyclics. Amitriptyline is equipotent in blocking the reuptake of noradrenaline and 5HT and similarly, as we mentioned in our article, the clomipramine metabolite desmethylclomipramine is a potent noradrenaline reuptake inhibitor. Recent studies (Seth *et al*, 1992; Nelson *et al*, 1991) have proposed the joint administration of an SSRI and a noradrenergic uptake inhibitor in patients with relative treatment resistance.

It is well known to drug firms and their marketing staff that whether doctors prescribe new drugs depends not only on the science they present the doctor with but also the doctor's own personality profile. Some always prescribe new drugs, some never. There is currently a place for taking the middle ground of using the new drugs in one's own clinical practice to find their place in the armamentarium of antidepressants. Treatment of all, particularly the more difficult, patients is likely to be by a single group of drugs. In patients who have failed to respond to a SSRI (and in psychiatric practice this may be as high as 40% of patients) prescribing of a tricyclic with attention to detail remains a necessary option. We indicated that some of the newer tricyclics have significantly lower toxicity in overdose than some of the first line tricyclics. Time will tell as to whether the SSRIs constitute a completely acceptable replacement for the tricyclic antidepressants or whether they simply increase the range of drugs available to us.

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Audit of above BNF dosage medication

DEAR SIRS

A recent study of Broadmoor has looked at prescribing habits for patients in special hospitals (Fraser & Heppel, 1992). This showed that 38% of men and over 60% of women received over 1 gram of psychotropic medication in chlorpromazine equivalents.

At the Reaside Clinic, the West Midland regional secure unit, a point prevalence study was carried out looking at patients who were receiving psychotropic medication greater than 1 gram of chlorpromazine equivalents (Wressell *et al*, 1990). On the day of the census there were 77 in-patients. Of these, five patients (6.5%) were on psychotropic medication at above the *British National Formulary* recommended dosage. Only one of the patients was on an acute admission ward; the rest were on the rehabilitation wards. All five patients were on depot medication; three of these (4%) were at a dosage above the BNF limits. All the patients had reasons for their high dosage clearly stated in the notes. All patients had a second opinion consent to treatment, because of their inability to give informed consent, which allowed medication to be given in excess of BNF limits. The improvements to the patients' mental health while on the high doses of medication were clearly stated. We noted no ethnic differences in the dosage of the medication compared with the population of the clinic as a whole (of the five patients one [20%] was Afro-Caribbean, one mixed race Afro-Caribbean and Asian compared with a 40% Afro-Caribbean population for the clinic as a whole).

Most of the patients who were on high doses had been on large doses of medication for some months. All of the patients were relatively young, mean age 34, range 22–58 years. There is little in the literature about prescribing above BNF limits although concern has been expressed about excessive dosages (Edwards & Kumar, 1984). None of this group of patients had evidence of side effects, including tardive dyskinesia.

The patients who are in-patients in regional secure units in general have severe mental illness. We felt that it was encouraging that of this group only 6%