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Correspondence

Editor: Ian Pullen

Contents: Duration of depressive illness/Tourette's syndrome and the amygdaloid complex/Propofol and ECT/Suicide prevention by general practitioners/Psychosis and multiple sclerosis/Adaptive behaviour scale in Down's syndrome/Fluoxetine and suicidal behaviour/Periodic psychosis associated with the menstrual cycle and childbirth/Gender differences in schizophrenia/Carbamazepine and episodic dyscontrol/SSRIs and tricyclic antidepressants/HTLV-1 Revisited.

Duration of depressive illness

SIR: The influence of premorbid neuroticism on duration of depressive illness, as studied by Scott *et al* (*Journal*, November 1992, **161,** 633–637), seems clinically and intuitively correct. The interval between the onset of the illness and receiving treatment, which was found to be the second major influence, also seems likely to be true, but I have a question about the method, the answer to which I cannot find in the paper. The duration of illness is taken as the time from onset to recovery and it is self-evident that the longer the period before treatment, the longer will be the total duration of illness. A more interesting question is whether the duration of illness before treatment predicts the time taken to respond to treatment once it is given. That result would really support the conclusion of Dr Scott *et al* that major depression should be treated at the earliest stage possible if chronic symptoms are to be avoided. Can they clarify their method in this regard, and do they have data to support the conclusion in favour of early treatment?

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AUTHOR'S REPLY: As indicated, it seems logical to suggest that the longer an illness persists before treatment, the longer the total episode length, and so it is important to know the impact of early or late introduction of treatment on the outcome of depression. Firstly, we would like to consider previous publications that shed light on this problem. Three studies suggest that the longer an episode persists before treatment is introduced, the less likely it is to respond to treatment (Kiloh *et al*, 1962; Deykin & DiMascio, 1972; Paykel *et al*, 1974). By inference, this suggests an extended episode even after the introduction of treatment.

Briefly reanalysing our data, it was found that the length of episode prior to the introduction of treatment was significantly correlated with length of episode after the introduction of treatment (Pearson $r=0.4$; $P<0.05$). However, plotting a regression curve suggested a non-concordance rate of about 35%. A separate analysis of the 50 non-chronic depressives (episode of longer than 2 years) in this study and a group of 50 chronic major depressives has also been undertaken. The difference in the 'no treatment interval' just failed to reach significance ($P<0.06$), but there was a trend for those with a longer 'no treatment interval' to suffer a prolonged illness episode even after the introduction of treatment.

In conclusion, we would suggest that there is tentative evidence to support the hypothesis that duration of illness before treatment predicts response to treatment, once it is given. Further research on the 'no treatment interval' is clearly required. The method of our study can be further improved, firstly by improving the reliability of the estimation of the 'no treatment interval', which was relatively crude, and secondly by careful prospective monitoring of the treatment received by the cohort. In our study, difficulties in collating data meant that 75 mg of a tricyclic antidepressant or its equivalent was the most reliable definition of 'active treatment' that we could achieve. The correlation between 'no treatment interval' and response to treatment after its introduction may be enhanced if the definition of 'active treatment' were for example 150 mg.

DEYKIN, E. Y. & DIMASCIO, A. (1972) Relationship of patient background characteristics to efficiency of pharmacotherapy in depression. *Journal of Nervous and Mental Diseases*, **155,** 209–215.