# Correspondence

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## Problem substance use and schizophrenia

McCreadie *et al* (2002) report on the problem use of drugs and alcohol by people with schizophrenia. This is an excellent study as the pattern of use by patients is compared with controls from the general population, although the findings – that problem use is greater among patients – are unsurprising. It is impressive that the study included tobacco use, often disregarded as a 'problem' drug despite the obvious financial implications for patients surviving on state benefits. Previous studies quoted in the paper indicate that patients with schizophrenia often have been smoking for many years prior to the onset of the illness.

We are very interested to know whether the data collected for the study show that particular groups of patients appear to be more at risk from problem substance use, in order to focus efforts on helping them. Our experience is that admission to a psychiatric ward leads to increased tobacco use, and patients who have given up smoking recommence and continue smoking post-discharge, despite anti-smoking strategies. Also, we would like to know whether the study shows, or the authors know of, cultures that may be at lesser risk for developing problem use, accepting that numbers of ethnic minorities in the study sample may be small.

**McCreadie, R. on behalf of the Scottish Comorbidity Study Group (2002)** Use of drugs, alcohol and tobacco by people with schizophrenia: case–control study. *British Journal of Psychiatry*, **181**, 321–325.

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**Author's reply:** Bates & Rutherford raise some interesting points. I am impressed by their experience that admission to a psychiatric ward leads to increased tobacco use; this is certainly worthy of more-detailed study.

Smoking habits of people with schizophrenia probably do differ in different cultures. Colleagues in south India, where I have carried out much research, have found that people with schizophrenia probably smoke less than the general population. This is largely for economic reasons. Most are unemployed or in part-time employment. There are no state benefits, and therefore patients cannot afford to buy cigarettes.

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## Betel use and schizophrenia

The Scottish Comorbidity Study Group has highlighted again the problem of greater use of drugs and alcohol, and especially tobacco, among patients with schizophrenia (McCreadie *et al*, 2002). An underrecognised comorbidity, however, especially in developing countries, is that of chewing betel nut (*Areca catechu*), along with the betel leaf (*Piper betle*) and lime.

In a preliminary study conducted in the North Colombo Teaching Hospital, Sri Lanka, we observed that a higher proportion of patients with schizophrenia chewed betel compared with control subjects. The frequency of chewing betel was also higher among the patients with schizophrenia. A recent study from Micronesia (Sullivan *et al*, 2000) has shown that betel chewing may in fact have a beneficial effect on patients with schizophrenia in terms of reducing both positive and negative symptoms. They postulate that the muscarinic agonist action of the betel nut alkaloid, arecoline, may provide an explanation.

However, betel chewing is an important risk factor for oro-pharyngeal carcinoma, and contributes significantly to oral health-related morbidity and mortality (Trivedy *et al*, 2002). Thus, the dual diagnosis of schizophrenia and betel chewing should not be missed, and services to address this problem should receive priority in many developing countries.

**McCreadie, R. G. on behalf of the Scottish Comorbidity Study Group (2002)** Use of drugs, alcohol and tobacco by people with schizophrenia: case–control study. *British Journal of Psychiatry*, **181**, 321–325.

**Sullivan, R. J., Allen, J. S., Otto, C., *et al* (2000)** Effects of chewing betel nut (*Areca catechu*) on the symptoms of people with schizophrenia in Palau, Micronesia. *British Journal of Psychiatry*, **177**, 174–178.

**Trivedy, C. R., Craig, G. & Warnakulasuriya, S. (2002)** The oral health consequences of chewing areca nut. *Addiction Biology*, **7**, 115–125.

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## ECT and old age psychiatry

The editorial on electroconvulsive therapy (ECT) by Eranti & McLoughlin (2003) describes the current status of ECT as a treatment option. They have noted that the use of ECT is declining and also highlight that in a study from Edinburgh (Glen & Scott, 1999) a reduction in the number of recipients aged 18–65 was noted. While discussing the future of the ECT clinic, they raise concerns about how this reduced use could lessen clinical interest and how this could, in turn, affect future psychiatric trainees with respect to obtaining experience in ECT. They rightly highlight the need for this treatment option to be readily available for our patient group.

In this context, I want to report some of the findings from a study my colleagues and I presented as a poster at the annual meeting of the Royal College of Psychiatrists in Edinburgh in July 2000. The study looked at trends in ECT usage in the busy ECT clinic at the Royal London (St Clement's) Hospital. It was a retrospective, chart-based study, covering a 3-year period during 1996–1999. Demographic and clinical data, which included response to ECT, were noted. There was a reduction in the number of patients who received ECT from 25 (171 total ECT episodes) in the year 1996/1997 to 12 (113 ECT episodes) in the year 1998/1999. Of the patients who received ECT, 70% were women and about 65% of the sample were aged above 60 years. A good response was noted in 45% of patients and, of this group, 70% were aged more than 60 years. The most common indication was depression and most of the findings of the practice of



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