The findings in relation to areas of residence demonstrates the additional clinical load above the immediate district commitment which a general hospital psychiatric department carries. A final comment should be made about the complexity of many referrals, the unusual setting for psychiatric interview, the multiple factors requiring attention in deciding clinical management *(11)*, and, as we have seen, the expectations that trainees will cope in the emergency situation, preferably without recourse to admitting the patient to an expensive hospital bed. Patients had disturbed social circumstances, sometimes serious psychiatric and physical illnesses, unpredictable and life-threatening behaviour, and complicating alcohol abuse with occasional violence. These patients make challenging demands on trainees in psychiatry but provide them with very valuable experience. This audit has answered the questions posed and has raised issues concerned with supervision and training in clinical management of emergency patients. The lessons to be taken from this audit are firstly that closer support and supervision for trainees in A & E consultation work is warranted, and secondly that as far as modern service conditions allow, undue pressure should not be applied to trainees to maintain potentially suicidal patients outside hospital.

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LETTERS TO THE EDITOR

Side effects of moclobemide in depressed patients refractory to other treatments

Sir, –

The key wording in the title of Professor Fahy's paper *(1)* about side-effects of moclobemide is that these were recorded in depressed patients "refractory to other treatments". In other words, these were very atypical of depressed patients generally, both in their "extensive diagnostic co-morbidity" and in their previous refractoriness to a variety of treatment methods.

Patient 1, for instance, was not only resistant to all other treatments, both pharmacological and psychological, but had "an intense psychotic reaction" when given alprazolam – a far from everyday occurrence. Patient 4 had a history of epilepsy, which surely cannot be irrelevant to outbursts of rage. Patient 5 presents the puzzling history of tolerating classical MAOIs (combined with tricyclics) without difficulty, yet having "racing thoughts" whilst on moclobemide; the chronic panic disorder from which she suffers is, of course, not uncommonly associated with symptoms of depersonalisation. Patient 6 was irritable whenever depressed or premenstrual. Patient 7 does not seem to have had any problems with moclobemide apart from the fact that it alone did not cure her schizo-affective disorder – which is not very surprising. Patient 8 had previously attributed feelings of unreality to dothiepin, but these symptoms were probably as unrelated to that drug as they were to moclobemide. Patient 9 seems to have had no different problems whilst on moclobemide from those he had before; his global personality disorder would have been very unlikely to resolve with an antidepressant alone. Patient 10 failed to tolerate dothiepin also; her eventual recovery was very likely a function of time, since no previous depressive history is recorded. Patient 11 did not respond to tricyclics, and her eventual outcome is not recorded. Patient 12 suffered primarily from a paranoid disorder and made no complaints possibly relevant to moclobemide. Patient 13 suffered from chronic panic disorder, so that the same comment applies to her as to Patient 2; that she complained of 'tunes in the head' when taking two entirely different antidepressants must make their connection with any drugs very questionable. Patient 14 responded predictably to a course of ECT, and made no complaints relevant to moclobemide; the same is true of patient 15.

In the case of Patients 2 and 3, there is no obvious alternative explanation for the symptoms said to be related to moclobemide, although feelings of unreality can occur during courses of ECT, even when no drugs are involved.

So far as the literature is concerned, the most recent authoritative review *(2)* concludes that, "moclobemide appears to be devoid of the central excitatory effects . . . associated with the irreversible MAO inhibitors". In placebo-controlled studies, the only unwanted effect occurring significantly more often with moclobemide was nausea – and that is only 10% of subjects. Although this drug is clearly not sedating, the evidence was that it "appears to produce little central excitation".

Professor Fahy is a distinguished clinician, and no one would wish to question the accuracy of his report. However, the only take-home message from this paper is that depressed cases at the extreme end of the spectrum of clinical difficulty will continue to need complex, prolonged, and often multi-modal management. It would seem highly premature on the basis of these case reports to propose any aetiological relationship between the clinical events described and the use of moclobemide.

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