We hope shortly to be able to address the issue of the Italian psychiatric system more directly, as for two years now it has been the subject of a large-scale evaluative research program by the National Research Council, in which this Laboratory is taking part.

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REVERSIBLE DEMENTIA AND DEPRESSION

DEAR SIR,

The paper by Rabins *et al* (*Journal,* May 1984, **144,** 488–92) emphasizes depression as a treatable cause of dementia and is a welcome move away from the illogical and somewhat misleading concept of 'pseudodementia'.

In their discussion the authors have acknowledged that depression can lead to cognitive change amounting to dementia; that primary dementing illness can produce depressive symptoms; and that a depressive illness may produce cognitive disturbance that is superimposed upon a dementia.

There is a further possible explanation for the co-existence of depression and dementia *viz.* brain dysfunction that gives rise to both dementia and depression. Rabins *et al* have noted that three of their patients remained cognitively impaired even after the depression was treated. Several of the series they have referred to (Nott and Fleminger, 1975; Ron *et al,* 1979; Wells, 1979) have suggested that the incidence of brain damage or dysfunction in terms of psychometry, EEG and PEG in patients with reversible or non-progressive dementia was greater than might be found in uncomplicated depression or other 'functional' illness. There is no evidence that these reverse with the resolution of the depressive or other illness. Unfortunately, we have no knowledge of the histopathological status of patients with depressive dementia. In showing that elderly depressives did not show significantly greater neuropathology than the normal elderly, Tomlinson *et al* (1968), of course referred to those depressives who did not show significant cognitive change.

Furthermore, several of the series referred to by the authors (e.g. Kiloh, 1961; Marsden and Harrison, 1972; Wells, 1979) have also indicated that dementia may occur at least in association with other 'functional' psychiatric illness, depression merely being the commonest such disorder. The explanation for dementia following depression may not be applicable to all those instances.

Hence it would be useful to bear in mind the possibility that some instances of dementia with depression may well be cases displaying dementia *and* depression as common phenomena of underlying pathology. Alzheimer's disease and Parkinson's disease are two conditions where dementia and depression possibly reflect brain pathology, with, of course, a more progressive course.

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DEAR SIR,

The longitudinal study by Rabin *et al* (*Journal,* May 1984, **144,** 488–92) is of importance for demonstrating that the cognitive deficits associated with depression in the elderly are, in general, likely to improve with resolution of the depression, which emphasises the need to avoid the misdiagnosis of depression as dementia in elderly patients. However, it seems unlikely that the patients in the 'demented—depressed' group of this study would have been diagnosed as demented by a clinician taking a full history and performing a competent mental state examination. Around two-thirds of this group had a previous history of affective disorder, four-fifths had delusions with a depressive content, one-fifth had a family history of affective disorder and symptoms of depressed mood, appetite and sleep disturbance were

prominent. Given these features it would seem most appropriate to have made a primary diagnosis of depression rather than 'dementia and depression'.

An important point demonstrated, though not discussed in this paper, is that tests such as the Mini Mental State Exam (Folstein *et al*, 1975), a score of less than 24 on which was used to diagnose dementia in this study, should not be used as diagnostic instruments although they are useful as measures of degree of cognitive impairment.

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DRUG COMBINATIONS FOR CHRONIC DEPRESSION

DEAR SIR,

Barker and Eccleston (*Journal*, March 1984, **144**, 317–19) describe a chronically depressed woman who responded to the combination of lithium/phenelzine/L-tryptophan but developed severe sodium retention problems. When given lithium/tranylcypromine/L-tryptophan she was unable to sustain improvement until carbamazapine was added.

I would like to describe a further chronically depressed case treated with lithium/tranylcypromine/L-tryptophan who, unlike Barker and Eccleston's case, showed not only rapid but sustained improvement. The patient concerned was a 63-year-old woman who for 3 years had been chronically depressed and had received 12 courses of ECT and had failed to respond to the combinations amitriptyline/thioridazine, lithium/mianserin and lithium/tranylcypromine. During exacerbations she showed irritability, social withdrawal, negativism, sleep disturbance and profoundly depressed mood. After one week on lithium carbonate (800 mg nocte) alone, tranylcypromine and L-tryptophan were added. Tranylcypromine 20 mg/day was given for the first 10 days then increased to 30 mg/day. L-tryptophan was gradually increased from 2400 mg/day to 3200 mg/day over the first 3 days with an increase to 4800 mg/day at the 8th day.

Within 5 days she showed clear improvement and was quite normal after 10 days. Over the last 4 years she has been maintained on lithium carbonate (800 mg nocte), tranylcypromine (10 mg b.d.) and L-tryptophan (1200 mg q.i.d.) with only one episode of depression occurring when lithium was stopped during an episode of diarrhoea/vomiting. Apart from an unexplained episode of lithium toxicity she has not shown any major unwanted side-effects, and in particular none of the sodium retention problems described by Barker and Eccleston.

If, as Barker and Eccleston suggest, 5-HT mechanisms are involved and an elevation of brain 5-HT function occurs, mention should be made of the possibility of major unwanted effects in the CNS. Animals given the combination lithium/tranylcypromine or tranylcypromine/L-tryptophan show a characteristic syndrome of hyperactivity thought to be due to a spillover of 5-HT at the CNS synapse.

Pre-treatment with lithium potentiates the syndrome of tranylcypromine/L-tryptophan and the occurrence of such a syndrome has been considered as predictive of the antidepressant activity of the agents involved (Grahame-Smith, 1971; Grahame-Smith & Green, 1974) However, the syndrome could also be equated to the symptoms sometimes seen in patients treated with MAOI/L-tryptophan, namely myoclonus, hyperreflexia, ataxia, ocular muscle oscillation and drowsiness (Baloh *et al*, 1982; Pare, 1963).

It is likely that this combination of agents is capable of producing both therapeutic and major unwanted effects, and as dosage is relevant to the production of the animal hyperactivity syndrome it would appear prudent to commence this combined treatment using low doses of agents with careful watch for CNS symptoms.

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PROGRESSIVE SUPRANUCLEAR PALSY

DEAR SIR,

Progressive Supranuclear Palsy (PSP) is a rare, non-