Correspondence

EDITED BY LOUISE HOWARD

Prescribing of atypical antipsychotics

Sir: Thomas & Lewis (1998) provide a succinct and useful analysis of the issues surrounding atypical antipsychotic drugs. In particular, they rightly emphasise the important role of clozapine for treatment-resistant patients. However, in relation to adverse effects of clozapine, they state that the complications of neutropenia are precluded by blood monitoring. We would question the authors' assertion.

The authors do not state a frequency for blood monitoring, so we presume they are referring to the Clozaril Patient Monitoring Service (CPMS) provided by Sandoz Pharmaceuticals, registration with which is mandatory for patients receiving clozapine in the UK. This level of blood monitoring can certainly reduce the incidence of adverse events, including death, related to neutropenia or agranulocytosis, but we do not believe that such events can be prevented by CPMS monitoring alone. Therefore, we take the view that it would be preferable to state that blood monitoring will reduce the incidence of, rather than preclude, complications associated with neutropenia. There has been at least one death of a patient on clozapine who was monitored precisely in accordance with CPMS procedures and additionally received other white blood cell counts, yet whose agranulocytosis could not be attributed to any other cause and in whom a fatal outcome could not be averted (Mangan & Toal, 1994).

We believe that advice to doctors who might prescribe clozapine should emphasise that clozapine occupies an important place in the treatment of hitherto treatment-resistant schizophrenia, but also that clinical vigilance to signs of infection and possibly additional blood monitoring may be required to minimise the incidence and adverse outcomes of neutropenia and agranulocytosis.

Mangan, B. & Toal, M. J. (1994) Agranulocytosis as a fatal complication of clozapine. *Irish Journal of Psychological Medicine*, **11**, 138–139.

Thomas, C. S. & Lewis, S. (1998) Which atypical antipsychotic? *British Journal of Psychiatry*, **172**, 106–109.

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Sir: The recent update on atypical antipsychotics (Thomas & Lewis, 1998) was both interesting and informative. However, the authors seem to endorse the use of divided doses of thioridazine, that is 50 mg t.d.s. (usual dose) and 800 mg (high dose), and trifluoperazine, 10 mg b.d. (usual dose) and 20 mg q.d.s. (high dose). The half-lives of thioridazine and trifluoperazine being 16–30 hours and 13 hours, respectively, there is little justification in using divided doses except in the initial stages when the dose is being titrated. Unnecessary divided dosing can reduce compliance with treatment, impair quality of life, increase side-effects such as drowsiness during working/waking hours, waste nursing time and increase the cost of treatment (Mirza & Michael, 1993; Gelder *et al*, 1996).

Gelder, M., Gath, D., Mayou, R., *et al* (1996) *Oxford Textbook of Psychiatry* (3rd edn). Oxford: Oxford University Press.

Mirza, K. A. H. & Michael, A. (1993) Cutting costs without cutting corners: a case for sound pharmacotherapy (letter). *Psychiatric Bulletin*, **17**, 562–563.

Thomas, C. S. & Lewis, S. (1998) Which atypical antipsychotic? *British Journal of Psychiatry*, **172**, 106–109.

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Authors' reply: Toal & Campbell are correct to point out that the blood monitoring performed by CPMS cannot prevent all cases of agranulocytosis. To date, over 15 000 subjects in the UK and Ireland have been exposed to clozapine and there have been two cases of fatal agranulocytosis (Atkin *et al*, 1996). In the first 14 080 cases, the risk of neutropenia was 2.6% and of agranulocytosis 0.71% (*Clozaril Newsletter*, 1997, issue 18, p. 3). The monitoring service would appear to reduce substantially the risk of developing clozapine-associated fatal agranulocytosis and neutropenia, but cannot completely preclude it. We agree that additional blood monitoring at times of infection would be prudent to ensure that the subject's white blood cell count is sufficient to mount a defence against the infection.

We also agree with Appadoo, Ashton and Carlton's comments. The table at the end of our paper (Thomas & Lewis, 1998, p. 108) was simply designed to compare the costs of the older antipsychotics with some of the newer atypical antipsychotics.

Atkin, K., Kendall, F., Gould, D., *et al* (1996) Neutropenia and agranulocytosis in patients receiving clozapine in the UK and Ireland. *British Journal of Psychiatry*, **169**, 483–488.

Thomas, C. S. & Lewis, S. (1998) Which atypical antipsychotic? *British Journal of Psychiatry*, **172**, 106–109.

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Irish ethnicity and mental health

Sir: I would like to comment on Bracken *et al*'s (1998) article on Irish ethnicity. The authors highlighted the mental health needs of Irish people living in Britain but in considering the Irish dimension in particular and ethnicity in general I would like to draw attention to the gender issues involved. There is a well-established literature on the subjective and objective experiences of Irish women living in British culture and the differences found compared with Irish men (e.g. Hickman, 1995; Gray, 1996). In considering the mental health of this or any ethnic group the contribution of gender to experience of ethnicity should not be ignored. Specific reference to the importance of gender in Irish ethnicity would have added even more weight to Bracken *et al*'s arguments.

Bracken, P. J., Greenslade, L., Griffin, B., *et al* (1998) Mental health and ethnicity: an Irish dimension. *British Journal of Psychiatry*, **172**, 103–105.

Gray, B. (1996) Accounts of displacement: Irish migrant women in London. *Youth and Policy: The Journal of Critical Analysis*, **52**, 22–29.

Hickman, M. (1995) The Irish in Britain: racism, incorporation and identity. *Irish Studies Review*, **10**, 16–20.

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Sir: Bracken *et al*'s (1998) editorial was interesting but lacked scientific validity, for two reasons.

First, the authors failed to justify why being Irish-born constituted an 'ethnicity'. Ireland is a multi-ethnic English-speaking country made up largely of people from Celtic, Norse and Anglo-Saxon backgrounds. In this respect it does not differ substantially from any other part of the British Isles. I can see little validity in the claim that the Irish make up a more distinctive racial, linguistic, anthropological or cultural group than those of any other region within the UK or the Republic of Ireland do. The ethnicity of the White communities in Dublin and London probably bear more similarity than those of Newcastle and London. Nationality is not the same as ethnicity.

Second, it is not valid to compare the English health statistics of those born in Ireland with those born in England. A more valid comparison would be to compare Irish immigrants to those from Tyneside, Cornwall or South Wales who have migrated to other parts of the British Isles. I would suggest that migrated communities emanating from any of these poorer areas would share similarly poor mental health statistics. This would suggest that socio-economic and migrational factors are of more importance than specifically 'ethnic' ones.

The underlying assumptions made by Bracken *et al* are that being Irish represents a distinct ethnicity, which suffers relatively poor mental health. They fail to justify either of these views.

Bracken, P. J., Greenslade, L., Griffin, B., *et al* (1998) Mental health and ethnicity: an Irish dimension. *British Journal of Psychiatry*, **172**, 103–105.

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Authors' reply We wholly agree with Dr Haley regarding the significance of gender when considering the mental health of Irish migrants in Britain. Irish women constitute an invisible minority within an invisible minority as far as mental health needs are concerned, although the literature on the experience of Irish women is less well-established than Dr Haley suggests. Our article was intended to highlight the neglect of Irish mental health needs in Britain as a whole and it was written in the hope that drawing attention to these needs might engender further research and intervention.

Dr Sandford's comments demand slightly more attention. His first assertion, that Irish migrants do not constitute a distinct ethnic and cultural minority within Britain, must be rejected. The fact is that they meet the principal criteria for defining such status as established by the Race Relations Act 1976 and subsequent judgements (Hickman & Walter, 1997) and are recognised as an ethnic group by both the Commission for Racial Equality and numerous statutory bodies within Britain. Dr Sandford's position implies a crude reductionism conflating 'biological race' with culture and ethnicity. Perhaps his view might be different if Irish people had green skin.

Regarding the suggested comparison of Irish migrants with indigenous internal migrants, we can only remark that it is commonplace in migrant health research to compare the health status of migrant groups with that of the indigenous population as a whole (e.g. Balarajan, 1995). Certainly in studies of physical health and mortality this is accepted practice (e.g. Marmot *et al*, 1984). Internal migration might indeed have a bearing on mental health, but Dr Sandford's suggestion becomes meaningful only if we accept his first contention that Irish migrants do not constitute a distinct group within the British population as a whole. The question of socio-economic factors remains open since, to our knowledge, no research exists which might explicate matters in the case of mental health. Available research does not support Dr Sandford's view that migration or socio-economic factors may be more significant than ethnic or cultural status in explaining the high excess mortality among the settled children of Irish migrants (Raftery *et al*, 1990; Harding & Balarajan, 1996).

Epidemiological research which has employed simple ethnic categorisations, such as White, Asian and African/Caribbean, has been successful in demonstrating differential health experiences among minorities in Britain. However, the major thrust of our paper is that such categorisations are not only simple, but simplistic, and tend to conceal as much as they reveal. There is a growing consensus among health researchers that the standard classification, based as it is on notions of racial difference, is inadequate and needs re-thinking. In two successive decades Irish-born people had the highest rates of psychiatric in-patient admission of any country-of-birth group within England and Wales, and among the highest rates of suicide and parasuicide. These findings have been almost wholly ignored by service providers and practitioners in psychiatry.

Balarajan, R. (1995) Ethnicity and variations in the nation's health. *Health Trends*, **27**, 114–119.

Harding, S. & Balarajan, R. (1996) Patterns of mortality in second generation Irish living in England and Wales: longitudinal study. *British Medical Journal*, **312**, 1389–1392.

Hickman, M. J. & Walter, B. (1997) *Discrimination and the Irish Community in Britain*. London: Commission for Racial Equality.

Marmot, M. G., Adelstein, A. M. & Bulman, L. (1984) *Immigrant Mortality in England and Wales 1971–78*. London: HMSO.

Raftery, J., Jones, D. R. & Rosato, M. (1990) The mortality of first and second generation Irish immigrants in the UK. *Social Science and Medicine*, **31**, 577–584.

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Risk of sudden death on high-dose antipsychotic medication: QTc dispersion

Sir: Since the publication of the 'Consensus statement' on the use of high-dose antipsychotics (Thompson, 1994), psychiatrists have been performing electrocardiograms (ECGs) on their high-dose patients. The rationale behind this is that it will detect conduction abnormalities, especially QT prolongation, associated with an increased risk of sudden cardiac death. It is recognised that the risk of a conduction abnormality due to medication is dose-related and is greatest with phenothiazines. Although more common at higher doses, QTc prolongation (>440 ms) is found in patients on the full range of antipsychotic dosages (Warner *et al*, 1995). There is also evidence to suggest that patients can have