Brit. J. Psychiat. (1974), **124**, 219–20

Correspondence

A DOUBLE BLIND TRIAL OF PHENELZINE AND AMITRIPTYLINE IN DEPRESSED OUT-PATIENTS

DEAR SIR,

We are pleased that Dr. B. M. King (*Journal*, October 1973, *123*, 492) has drawn attention to the possible importance of dosage in our 'blind' trial of phenelzine and amitriptyline reported in the *Journal* for July, 1973 (*123*, 63–7). In describing the daily dose of 15 mg. of phenelzine as 'cheeseparing', Dr. King wittily hit upon the *mot juste*. So great were the fears of cheese reactions, not to mention complications in the event of anaesthetics being required, at that time (1966) that our colleagues were reluctant to use the drug at all. However, this dosage, i.e. 2 tablets each consisting of either 7·5 mg. of phenelzine or 25 mg. of amitriptyline, was the *minimal* dose permitted, and was intended to allow for the occurrence of unpleasant side-effects. The usual dosage reached was 6 tablets daily, i.e. 45 mg. of phenelzine or 150 mg. of amitriptyline.

In another trial (1), conducted in the regional hospitals, the original idea of comparing the effects of phenelzine and amitriptyline had to be abandoned because risks to patients on MOAI drugs were regarded by the consultants as unacceptable. The pendulum may now be swinging back, and there is at present a trial in progress, conducted by Prof. Sir Martin Roth and Dr. C. Q. Mountjoy in this Department, in which the daily dose of phenelzine increases from 45 mg. to 75 mg. So far, we understand, no serious dose-related effects have been met with. We do not imagine that the last word has been said about the uses and abuses of MAOI drugs.

D. W. K. KAY.
R. F. GARSIDE.
T. J. FAHY.

Department of Psychological Medicine,
The Royal Victoria Infirmary,
Newcastle upon Tyne, NE1 4LP.;
and St. Loman's Hospital,
Palmerstown, Co. Dublin, Ireland.

REFERENCE

1. KAY, D. W. K., FAHY, T. & GARSIDE, R. F. (1970) A seven-month double-blind trial of amitriptyline and diazepam in ECT-treated depressed patients. *British Journal of Psychiatry*, **117**, 667–71.

THE MANAGEMENT OF RESISTANT DEPRESSION

DEAR SIR,

Drs. Shaw and Hewland are to be commended on raising an issue that has so far received little attention in the literature other than a resigned admission that it exists (1). The percentage of depressed patients who fail to respond adequately to conventional treatments is small, being approximately one in six patients (Medical Research Council, 1965), and often they are written off as 'character disorders' or perhaps 'schizophrenics' by their frustrated therapists. However, as the author suggests, a more comprehensive use of somatic therapy may make the difference between, on the one hand, chronic morbidity with possible suicide and, on the other, improved health with reintegration in the community.

Three points from their letter can be amplified. In treating resistant depression, many would agree that combining MAOI and tricyclic drugs is indicated. If one chooses phenelzine and amitriptyline, as Shaw and Hewland suggest and at the dose they indicate, it can be predicted that many responses will be less than satisfactory. Recent evidence indicates that a maximum dose of 90 mg. of phenelzine may be needed (2) and that a substantial number of people are rapid acetylators of this drug; in these it is probably no more effective than a placebo (3). From a small series of 14 patients treated here within the last year, the best and most sustained response has been found with a combination of tranylcypromine and amitriptyline. In most cases, however, isocarboxazid and amitriptyline are used. The former combination is used only if special indication warrants it. The least satisfactory results have come from using phenelzine and amitriptyline, perhaps for reasons already outlined above.

Another question to be answered relates to the optimal dose of drug for a given patient. In the above series, there was one patient who had absolutely no pharmacological response until a daily dose level of 80 mg. of tranylcypromine and 300 mg. of amitriptyline was reached, at which point she developed nocturnal confusion. This disappeared when amitriptyline was reduced to 200 mg. at night. Although not fully recovered, she was much improved and able to be discharged from hospital. Conversely, one patient derived enormous benefit after her amitriptyline was

https://doi.org/10.1192/bjp.124.2.219-a Published online by Cambridge University Press

reduced from 200 to 100 mg. and phenelzine, 15 mg. daily substituted. Perhaps maximum dosage of an antidepressant, whether singly or in combination, should be determined on the state of play existing between side effects and target effects: if the latter have not yet been reached, can one safely put up the dose, or are there already side effects which will prevent one doing so? It is my own impression that the best response to combination therapy occurs shortly after a course of ECT, even if the latter has not appreciably helped. Perhaps in some ways ECT 'softens up' the CNS to respond to combined drug therapy. There is, of course, no reason why ECT cannot be given concomitantly with combined therapy, although from Dr. Shaw's letter it appears that they gave the two in sequence. In our refractory case on high doses of antidepressants, the administration of 15 ECT alongside drug treatment was felt to be a necessary but not sufficient ingredient in her response.

Yet another method of treatment not referred to in Dr. Shaw's letter is continuous sleep therapy (4). One of the indications for this treatment is when all else has failed, and a decision regarding psychosurgery has not yet been made. Under narcosis it can be beneficial to repeat ECT even though its previous effect has been sub-optimal.

JONATHAN DAVIDSON.

Department of Psychiatry,
North Carolina Memorial Hospital,
University of North Carolina,
Chapel Hill, North Carolina 27514.

REFERENCES

1. SHAW, D. M. & HEWLAND, R. (1973) The management of resistant depressives. *British Journal of Psychiatry*, **123**, 489–90.
2. DUNLEAVY, D. & OSWALD, I. (1973) Phenelzine mood response and sleep. *Archives of General Psychiatry*, **28**: 353–60.
3. JOHNSTONE, E. & MARSH, W. (1973) Acetylator status and response to phenelzine in depressed patients. *Lancet*, *i*, 567–9.
4. WALTER, C., MITCHELL-HEGGS, N. & SARGANT, W. (1972) Modified narcosis, ECT and antidepressant drugs: a review of technique and immediate outcome. *British Journal of Psychiatry*, **120**, 651–62.

'TRUE AND FALSE EXPERIENCE'

DEAR SIR,

In his review of my book *True and False Experience* (*Journal*, 1973, *123*, 600) Dr. Michael Fordham criticizes the examples of psychotherapeutic work that I give because 'they say too little about when and to which patients such communications are beneficial and so make little contribution to knowledge'. I have some sympathy with him, as I have wondered myself whether they really do make a contribution, and, if so, in what way. But I would like to reply to his comment because I think it touches on a fundamental issue.

Psychotherapy consists, as does ordinary living, of a mixture of the spontaneous (in which the therapist relates to his patient as a unique, unpredictable, whole person) and the technical (in which the therapist manages his patient by means of fixed rules thought to be useful when dealing with certain kinds of people and situations). Although these two modes cannot be entirely separated in practice (and perhaps not even in theory) the person at the receiving end usually knows roughly which mode is in the ascendant. One of the points I was trying to make in my book was that psychotherapists (mistakenly in my view) usually take it for granted in their writings that the technical approach should be paramount: for instance, they say too much about when and to which patients various kinds of communication should be made.

It is more difficult, I feel, to pass on psychotherapeutic experience to others than is usually recognized. Roger Poole puts the problem succinctly in his recent book *Towards Deep Subjectivity*: 'Subjective method is the patient unravelling of the contradictions inherent in the idea of *two* objectivities in one society: one objectivity excluding the human being from the totality and the other insisting that he should be included in it.'

PETER LOMAS.

Lynwood,
June Lane, Midhurst,
Sussex GU29 9EW.

PASSING NASAL TUBE IN PSYCHOTICS

DEAR SIR,

Not infrequently we have patients who refuse oral feeds and have to be fed and medicated by a nasal tube. At times it is very difficult to pass a tube, even under sedation. This is particularly true of negativistic patients or patients with catatonic schizophrenia. I have tried the following method in such patients, with 100 per cent success.

I give the patient ECT (he is usually in need of it and his stomach, bowels and bladder are likely to be empty). As soon as the convulsions stop and the patient is in a flaccid state, I pass the tube and it goes in easily and smoothly.

G. D. SHUKLA.

Department of Psychiatry,
Institute of Medical Sciences,
Banaras Hindu University,
Varanasi 5, India.

https://doi.org/10.1192/bjp.124.2.219-a Published online by Cambridge University Press