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Letters to the editor

Prediction of antidepressant response

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In an article published in European Psychiatry, Stassen et al (1994) concentrated on the first signs of improvement observed during the course of treatment of a depressive state where early improvement might indicate a favourable response to later treatment. Their conclusions come from a meta-analysis of 11 studies involving 1,277 patients. We would like to put forward some observations concerning their findings.

Although the idea of estimating early on the therapeutic response (of treatment) and determining from this predictive elements of a later favourable response appeared interesting to us, several of the conclusions drawn however seem to us as somewhat ambiguous.

The first conclusion that the authors draw is that the beginning of improvement among responsive patients from day 3 up to day 28 (either a partial or complete response) follows a near identical progression whether the placebo or one of the active products (imipramine or moclobemide) is used. This observation, if confirmed, would not favour a specific action on the part of the antidepressant compared to the placebo, at least as far as its kinetic aspect is concerned. The antidepressant would only differ from the placebo by a superior number of patients responding to the treatment.

As far as the predictive effect of treatment during the course of the first week is concerned, the meta-analysis conducted by the authors has only in fact indicated an inverse correlation: 70% of responsive patients would show signs of early improvement. This assertion has little practical significance and the lack of information concerning the non-responsive patients or those only showing a partial response to treatment is a strong limiting factor. In their analysis of more than 1,000 patients, the authors do indeed show that 118 patients whose state was initially improved by imipramine did not become responding patients and that within the moclobemide group, 231 patients did not improved further either, inspite of early positive signs.

In their discussion, the authors deny specific effectiveness to the antidepressants *"the therapeutic qualities of these drugs do not consist in suppression of symptoms, but rather relate to their ability to elicit and maintain certain conditions which enable recovery. The time course of recovery becomes identical to spontaneous, natural remission of depressive episode"*.

However, the absence of clinical qualitative study along with the lack of a study concerning the non-responsive patients does not seem to us to permit the drawing of a definitive conclusion. The authors have in fact kept as a criteria or evaluation Hamilton's depression scale and have considered the different persentages of improvement likely to be chosen to define response to treatment. The meta-analysis did not allow them to conduct a qualitative study of depressive symptomatlogy. This analysis could prove useful in distinguishing the different types of early response to treatment; the one which would predict a later response, then recovery or that which would just lead to a partial remission, or would not be confirmed during later evaluations.

We can therefore form the hypothesis that the early stages of improvement in a depressive state could on the one hand concern the specific components of a depressive state but on the other hand could only concern the non-specific symptoms (disturbed sleep, loss of appetite, somatic problems etc). The early improvement of specific problems seems to us to be a stronger predicting factor than the improvement of 'peripheral' problems of depression. We would be interested in having the author's opinion on the above comments.

Stassen HH, Angst J, Delini-Stula A. Severity at baseline and onset of improvement in depression. Meta-analysis of improvement and moclobemide versus placebo. *Eur Psychiatry* 1994;9:129–36

Dietary interferences with lithium therapy

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Vairations of serum lithium concentrations are known in patients treated with lithium carbonate. These variations are frequently connected with some variables we know to influence serum lithium concentrations (variations of dosage, entity of sodium clorure in the diet, concomitant therapies, etc). Regarding this issue, we describe a case suggesting a variability factor, which even already considered, might be underesteemed in clinical practice.

GP is a 56 year-old married woman without somatic diseases, with a long history of bipolar I disorder (predominantly manic, without psychotic features), treated

with antipsychotic medications, with no sufficient benefits. Since our first contact she has been taking only lithium carbonate (300 mg, tid) with remission of her symptoms and balance keeping. Over a period of eight years, the patient's serum lithium concentrations have been in a range between 0.50 and 0.60 meq/L. Patient compliance has always been good and ehanced also by the presence of insight degree and by a close control by her relatives.

Afterwards, one of the follow ups revealed a strong reduction of lithium level (values of 0.10 meq/L) without any change in the lithium carbonate dosage. A different laboratory exam confirmed the same result. Another follow up revealed that the patient usually drank water in which she added an effervescent tablet – a product well-known on the Italian market which is handy-packed and gives an 'effervescent and digestive dinner water'. Each pack contains 10 g of sodium bicarbonate added with malic and tartaric acids in quantities not exactly known. We suggested to the patient to stop the use of this drink and undergo the laboratory exam again. The following lithium concentration dosage showed values of 0.40/0.50 meq/L. A sudden new decrease of lithium values to 0.20 meq/L, confirmed in double laboratory testing, followed the drink re-assumption.

Obviously, this product, like other alkalinizing agents, if used frequently and in large quantities, is able to decrease the serum level of lithium. Because of the popular use of this product and others which contain high quantity of salts, we suggest to focus on their possible interference with lithium therapy. This issue becomes particularly important especially for those patients who are used to taking this kind of product and who do not make regular follow-up of lithium concentrations. For this reason there might be a risk of a decrease in drug blood levels with following relapse or withdrawal symptoms onset, not otherwise explainable.

Agenda

European psychiatry: a force for the future joint congress, London 7–12 July 1996

The 8th Congress of the Association of European Psychiatrists (AEP) will be held in London, 7–12 July 1996, and will be combined with the Annual Meeting of the Royal College of Psychiatrists. The AEP has increasingly become the main forum for scientific exchange amongst psychiatrists from the different European countries, and the last congress, held in Copenhagen in 1994, attracted over 2,500 psychiatrists. It is anticipated that the 8th congress in London will be even more successful.

The congress will have organised symposia, free communication and recent research symposia, round table debates, and poster presentations. In addition there will be an extensive social programme. Also, there will be the opportunity for psychiatrists from different countries to join together to discuss the areas of mutual interest concerning the development of professional issues in different countries, and the semi political issues concerning psychiatry in various countries.

Further information can be obtained from the AEP Congress Secretariat, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, UK. The deadline for abstracts for the congress is January 1996. Those wishing to make other suggestions for the scientific programme should contact Prof R Murray, Chairman of the Scientific Committee, at the Congress Secretariat.