Westerner to visit often sensitive institutions. Although I am aware of some professional colleagues who are involved or keen to develop links with Russia (or indeed other states of the former Soviet Union (e.g. Jacoby & Oppenheimer, 1994)), I would be pleased to hear directly from motivated others so that the most effective and coordinated strategy can develop to maximise the funding and contacts available. The issues are fascinating and the welfare of huge numbers of patients is at stake.

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Antidepressants and breast-feeding

Sir: The paper by Duncan and Taylor (*Psychiatric Bulletin*, September 1995, **19**, 551–552) regarding the use of antidepressants in breast-feeding mothers is a timely reminder of the need for judicious prescribing for these women, and highlights the paucity of published advice. A previous review (Buist *et al*, 1990) reviewed the meagre literature on this topic, and described special pharmacokinetic concerns affecting the infant, including erratic absorption, fluctuating plasma protein binding and reduced capacity to metabolise and excrete drugs. Unfortunately most drug data sheets unhelpfully recommend their use only 'where potential benefits outweigh possible risks', and inform that safety in lactation has not been established.

It can be recognised, however, that specialist centres have generated a wealth of experience in prescribing for this group, and this is so in North Staffordshire where lofepramine is the drug of choice for depression in breast-feeding mothers at the Charles Street Mother & Baby Unit. Lofepramine is a noradrenaline reuptake inhibitor, and meta-analysis studies have confirmed that it is at least as effective an antidepressant as other tricyclics. In common with other antidepressants, it is crucial to remember that hepatic and renal problems in the breast-fed infant are contraindications; lofepramine has been implicated as a rare cause of liver disorders and hyponatraemia in adults.

Duncan and Taylor draw attention to the suggestion that tricyclics with a short half-life are less likely to pose a risk of accumulating drug levels in the infant. Lofepramine also compares well in regard to this pharmacokinetic point, with a half-life of as short as 1.6–5.0 hours, compared to imipramine (8–16 hours) and amitriptyline (32–40 hours). *In vitro* studies indicate that lofepramine shares at least three metabolites with imipramine, and has a further three unique ones. Desipramine is an active metabolite common to both imipramine and lofepramine, and is about five times as toxic as lofepramine with a half-life of approximately 8 hours. However, it has been noted that the ratio of didesmethylimipramine to desipramine is higher in lofepramine metabolism compared to that of imipramine, and is a possible reason for its safer therapeutic profile (Strandgarden & Gunnarson, 1994).

Lofepramine is thus well tolerated because of mild anticholinergic effects, while low cardiotoxicity secures an improved risk: benefit ratio due to its relative safety in overdose, with safer prescribing to depressed out-patients who may also have small children.

We believe there is a need for wider sharing of empirical clinical expertise in the absence of substantive guidelines, and recommend that lofepramine be considered the first-line tricyclic treatment of depressive illness in nursing mothers in preference to imipramine and amitriptyline.

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Learning difficulties or mental retardation?

Sir: After reading an advertisement for a book entitled *Dyslexia and Other Learning Difficulties*, published by the Oxford University Press, I picked up my copy of the June 1995 issue of the *Psychiatric Bulletin*. On page 19, I noticed a review of a report on "Sexual Abuse and People With Learning Difficulties", by Katie Drummond, who is associated with the Division of Psychiatry of Disability of the St George's Hospital Medical School. This is followed by a review of a document on the prevention and treatment of sexual abuse of adults with 'learning disabilities' in residential settings.

The above terminology may have the virtue of being politically correct, but it is extremely confusing and does not lend itself to the clear description of clinical entities. Is there any good reason why British psychiatrists and the *Bulletin*

should reject the language of ICD–10 and DSM–IV when the topic under discussion is mental retardation?

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Discharge communication

Sir: The audit described by Shah and Pullen (*Psychiatric Bulletin*, September 1995, **19**, 544–547) was of particular interest to me, as I am carrying out an audit of discharge communication with primary care in our own service. We have not as yet addressed the issue of patient access to discharge summaries; the authors point out the importance of this, and I hope to incorporate relevant standards into our own project. However, I was concerned to find the avoidance of jargon as a standard by which our letters might be judged.

The examples quoted were non-standard versions of recognisable diagnoses and examination findings, but is this all that is meant by 'terms which are not intelligible without explanation' (*Access to Health Records Act*, 1990)? Surely terms such as 'borderline personality disorder' or 'passivity phenomena' are no less jargonistic by this definition? Specific terms exist for a reason, namely the succinct communication of assessment, treatment and prognosis to other professionals who understand them. It would seem onerous to suffix each term with bracketed explanations of the context in plain English. The alternative of providing large amounts of information to patients on receipt of their records with which to interpret these terms would be helpful to some, but confusing for others, and is no more sensible as a policy.

I would be interested to hear from Shah and Pullen as to how they dealt with this issue in their own audit. Certainly, letters should be written in plain error-free English, using standard psychiatric terms only. Easy access should be provided to the responsible consultant or an independent doctor if patients wish further explanation or clarification. Perhaps the real problem lies in the rarity with which we give personal written accounts to patients of our explanations, a measure which might aid understanding and insight, as well as promoting a more collaborative approach.

Access to Health Records Act 1990. London: HMSO.

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The misuse of alcohol in elderly psychiatric patients

Sir: We would like to present our findings from a survey on the use of alcohol in elderly psychiatric in-patients.

For a three month period, we identified all patients over 65 years of age, consecutively admitted to an acute psychiatric hospital. After obtaining patients' consent, we took a detailed alcohol history, particularly focusing on the alcohol consumption in the month prior to admission. In addition, we also administered the CAGE and the Short Michigan Alcohol Screening Test (SMAST; Selzer *et al*, 1975) questionnaires, and obtained a corroborative informant history when this was available. Of 89 consecutive admissions, 64 consented to the study (72%). All non-consenting patients had significant cognitive impairment, and were unable to consent as a result.

We found that 42% of the consenting population had used alcohol in the month prior to admission and 12.5% of patients had been exceeding the Royal College of Psychiatrists' recommended safe limits of alcohol consumption (i.e. more than 14 units per week for women and 21 units for men). A further 3% of patients were identified by the screening instruments used as having had previous problems with alcohol though not having exceeded the recommended safe limit in the month before admission. Alcohol misuse was significantly more common in male patients. Case notes failed to identify approximately one-third of patients who had misused alcohol.

These findings are broadly in line with those of Mears & Spice (1993), who identified 19% of psychiatric in-patients as being 'problem drinkers'. They also help to highlight two important and related issues: first it is certainly possible that the consumption of alcohol may contribute to the physical health problems, social difficulties, psychopathology and consequent need for admission, in a sizeable proportion of elderly patients with psychiatric problems. Furthermore, there is a continued need within the profession to raise the awareness of the possibility of alcohol misuse within this vulnerable population group.

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