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THE PROGNOSIS OF DEPRESSION IN OLD AGE: THE CASE FOR LITHIUM THERAPY

DEAR SIR,

The elegant study by Murphy (*Journal,* 1983, **142,** 111–13) is another confirmation of the poor prognosis of depressive illness in late life. The study, primarily an investigation of the 'importance of social factors in influencing outcome', could not—by reason of its design—determine the contribution of physical treatment to this outcome. Murphy rightly concluded that the case for maintenance treatment with antidepressant medication or for lithium prophylaxis remains an open one: 'a prospective study of the role of maintenance therapy in these patients would be very valuable'.

We would like to provide evidence for the efficacy of lithium prophylaxis in depressions of late life.

Forty-four male and 104 female patients with recurrent affective disorders were studied. Patients had been attending the lithium clinic for periods varying from 1 to 14.5 years (mean 4.9 years). All patients had received lithium carbonate in the form of sustained release tablets (Priadel). Lithium was given once daily, at night, to achieve plasma levels of 0.8–1.2 mmol/l, 12 hours later. Affective morbidity over time was measured by the Affective Morbidity Index (AMI), a composite index of the severity and duration of both manic and depressive episodes each patient had suffered during the period studied (Coppen *et al,* 1973). Among these patients there were 47 who had started lithium prophylaxis in late life (at the age of sixty or above). Table I shows comparisons between this group and groups who had started lithium prophylaxis at earlier ages. There were no significant differences between these groups in terms of their previous morbidity and their AMI. The elderly group, however, had a significantly shorter duration of lithium therapy than the other younger groups. There was no significant correlation between duration of lithium therapy and AMI in the whole group.

TABLE I

General details of patients, and relationship between age and morbidity during lithium therapy (results expressed as mean ± SEM)

Age when lithium started (yrs)	n		Polarity		Episodes prior to lithium	Years on lithium	AMI+
	M	F	Unip.	Bip.			
60 and above	4	43	42	5	4.9 ± 0.6	3.8* ± 0.4	0.18 ± 0.03
40 – 60	31	48	58	21	4.2 ± 0.3	5.5 ± 0.4	0.17 ± 0.02
Less than 40	9	13	17	5	4.4 ± 0.6	5.3 ± 0.7	0.14 ± 0.03

* Significantly lower than (40 – 60 yrs) group $P < 0.01$ and (less than 40 yrs) group $P < 0.05$.
+ Affective Morbidity Index (Coppen *et al,* 1973).

TABLE II

Morbidity and plasma lithium level in 22 elderly patients before and during trial period (results expressed as mean ± SEM)

Plasma lithium level (mmol/l)	n		Polarity		AMI	
	M	F	Unip.	Bip.	Before trial	During trial
Above 0.8	0	8	6	2	0.16 ± 0.08	0.17 ± 0.06
0.60 – 0.79	2	4	5	1	0.40 ± 0.17	0.36 ± 0.12
0.45 – 0.59	0	8	7	1	0.22 ± 0.15	0.36 ± 0.20

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We also carried out a double-blind prospective study over a year to examine the changes in affective morbidity and side effects of patients who were randomly allocated to undergo or not to undergo a reduction in their daily dose of lithium (Coppen *et al,* to be published). Among the patients studied there were 22 patients who had lithium prophylaxis in late life (aged 60 years and above).

Table II provides analysis of the relationship between AMI and plasma lithium level for these patients. As shown, there were no significant differences in AMI over one year between elderly groups maintained at three different ranges of plasma lithium concentration. The three groups had comparable AMI during equivalent periods before trial. In the whole group investigated subjective side effects such as tremor and plasma thyrotropine (TSH) concentrations showed significant reductions in patients maintained at levels ≤ 0.79 mmol/l compared to those maintained at levels ≥ 0.80 mmol/l.

We have also studied the relationship between the endogenous – non-endogenous distinction in unipolar depressive illness and response to antidepressive therapies (Abou-Saleh and Coppen, 1983a). Endogenicity as measured by the Newcastle Diagnostic Scale (Carney *et al,* 1965) showed a curvilinear relationship to response to ECT and antidepressant medication after four weeks of treatment. Response to prophylactic lithium over one year, however, showed a linear relationship to the Newcastle scores: patients with the highest scores, many of whom had psychotic symptoms, had the best response to lithium. We have elsewhere shown that endogenous-psychotic depressive illness is an illness of middle and old age: the Newcastle scores of all 347 patients showed a significant positive correlation with their age (Abou-Saleh and Coppen, 1983b).

These results make a strong case for lithium in the prophylaxis of recurrent affective disorders in late life. Considerable improvement could be predicted at lower plasma lithium levels that are associated with reduced subjective side effects and reduced toxicity to the thyroid gland.

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ERRATUM

I refer to the paper "Clinical Characteristics of Akathisia" (*Journal,* **143,** 139–50) in which unfortunately there has been an important error on page 147 in the section entitled "Drug treatment", which affects the sense of this paragraph. It should read:

> "Out of twenty patients treated with anticholinergic agents only six, characterized by concominant severe parkinsonism, improved. Akathisia was an invariable accompaniment of severe parkinsonism and in this context only responded to anticholinergic drugs, suggesting there may be two distinct types of early-onset akathisia, one related to severe parkinsonism and one not, possibly reflecting different pathophysiological mechanisms".

The phrase "characterized by concominant severe parkinsonism" has therefore been placed in the wrong sentence. This change was reflected in the corrected version of the proof. As this error seriously affects the sense of an important paragraph of the paper, I would be grateful if this could be included as "an erratum" on the reprints of this paper and as a note in a future edition of the journal.

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