inoperable glioma; one alcoholic was unable to walk because of peripheral neuropathy; one hypertensive patient had angina pectoris, another was diabetic, and a third required surgery for varicose leg veins; six men had anaemia of nutritional origin – one had undergone sub-total gastrectomy 30 years previously; one young patient had a marked strabismus; three men had had duodenal ulcers, two having received surgery for this; two had a history of hepatitis; and five had received anti-tuberculosis chemotherapy within five years of admission. Ten of the NFA patients were grossly obese.

The finding of a high physical morbidity among *both* urban groups is in keeping with other reported work (Feldman *et al*, 1974). The fact that all four groups shared this unenviable record is most likely related to the fact that they had psychiatric illnesses (Cutting, 1980; Sims, 1978; Sims & Prior, 1978).

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Late Paraphrenia or the Paraphrenias

SIR: Holden (*Journal*, May 1987, **150**, 635–639) perpetuates the confusion surrounding paranoid states in the elderly. A major contribution to this has to be the continuing reluctance to diagnose schizophrenia arising for the first time in patients over the arbitrary age of 40 or 45.

Holden appears to be using the term 'late paraphrenia' in a very broad sense, including within the definition all cases of paranoia arising *de novo* after the 60th birthday. This is not in keeping with the clear definition of Kay & Roth (1961) he quotes.

I suspect that the 'organic' group could have been identified at the time of the initial contact, and it may be that the Gresham Ward Questionnaire is not sensitive enough to identify clinically important levels of poor cognitive function. It is interesting to note that the 'organic' group comprised 35% of the final sample, a figure not dissimilar to Post's "up to 30%". Paranoid symptoms are well known in patients suffering from organic brain syndromes (Ballinger *et al*, 1982) and the poor prognosis for organic brain syndromes has been known for some years (Roth, 1955; Christie, 1982; Blessed & Wilson, 1982).

I cannot agree with Holden that the differences between the concepts of "late paraphrenia" (Kay & Roth, 1961) and "persistent persecutory states of the elderly" (Post, 1966) have not been clearly resolved. The title of the Kay & Roth (1961) paper should leave one in no doubt as to their view of late paraphrenia. My own review of the term (Grahame, 1982) concluded that late paraphrenia is one of the schizophrenias, and this was supported by a later clinical study (Grahame, 1984).

Holden's final paragraph is, for me, the most confusing and I cannot see how the data presented support such a conclusion. Organicity is important in the genesis of 'persistent persecutory states of the elderly' but not of 'late paraphrenia', which in my view is as homogenous a clinical syndrome as any known to psychiatry. After all, there is no dispute about schizophreniform psychosis secondary to, say, trauma in young patients and the functional schizophrenias. The fact that some patients with late paraphrenia subsequently develop an organic brain syndrome should not necessarily lead one to say that the late paraphrenia was a symptom of an organic brain syndrome. Just over 40% of patients in the Blessed & Christie (1982) study had an organic brain syndrome, and they comment that their findings "again lend little support to the idea that functional illness in old age is the harbinger of senile or arteriosclerotic psychosis". Inspection of Table I of Blessed & Wilson (1982) shows what they consider late paraphrenia to be.

Finally, had Holden interviewed his patients using the Geriatric Mental Status Interview, he may well have found more patients reporting first rank symptoms which, in turn, may have had a significant effect on his final groupings.

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Comparative Trial of a New Antidepressant

SIR: There are 16 tricyclic and related antidepressants currently on the market. It seems likely that most psychiatrists use only a small number of them routinely. Before any more new antidepressants are added to this list, how insistent should we be in requiring that standardised methodologies be employed when testing their efficacy?

Levine *et al* (*Journal*, May 1987, **150**, 653–655) showed that fluoxetine was as effective an antidepressant as imipramine. However, their study did not include a placebo control to establish the relative efficacy of both of these drugs. The reason for this not uncommon omission is that imipramine is considered to be of proven efficacy and, therefore, a reliable benchmark against which new antidepressants can be measured. How justified is this assumption?

In two extensive reviews of the literature, tricyclic antidepressants were not found to be superior to placebo in 35% (Morris & Beck, 1974) and 41% (Thomson, 1982) of studies. Swallowing an inert placebo leads to a significant improvement in between 30% (Morris & Beck, 1974) and 50% (Medical Research Council, 1965) of those suffering from depression. Mild side-effects (which fluoxetine possesses) are associated with greater drug success, while zero or severe side-effects are associated with less success (Brune *et al*, 1962). The advantage of tricyclic antidepressants over placebo is significantly less when an active (atropine) placebo is used instead of an inert substance (Thomson, 1982). Thirty per cent of depressed patients do not respond to tricyclic antidepressants (Medical Research Council, 1965): in the Levine *et al* study this figure was approximately 50%.

Thus the universal and invariable efficacy of tricyclic antidepressants has yet to be demonstrated. Therefore, imipramine and other 'standard' antidepressants should not be used as the sole agent in comparative studies. Levine *et al* did not use a placebo control, so we cannot be sure whether the improvement in depressive symptoms was due to a specific psychotropic, or an active placebo, effect.

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Comparative Hospital Survey of Psychotropic Drug Prescribing

SIR: Muijen & Silverstone (*Journal*, April 1987, **150**, 501–504) showed that the hospital (hospital A) with the lowest prevalence of polypharmacy was the only one with an associated psychopharmacology unit. We have compared the authors' results with our acute in-patient population. Our data is obtained from a unit in our hospital, the population of which can be compared to that of the authors' hospital C. Ours is a teaching hospital, but has no association with any psychopharmacology unit.

Seventy-eight patients admitted in the past year were included in the study. All psychotropic drugs given on the seventh day of admission were recorded from case records; we presumed that a final diagnosis was reached and medication was started by one week after admission. The rest of our methodology is similar to that of the authors' study.

The results showed that more than one psychotropic drug was given to 49 patients (63%). This figure is close to the authors' figure for hospital A. More than two drugs were given to 23 patients (29%) and more than three drugs were given to 8 patients (10%). One patient received no drugs, one drug was given to 23 patients (29%), two drugs were given to 28 patients (36%) and three drugs were given to 18 patients (23%). Benzodiazepines were given to 22 patients (28%). More than one antipsychotic drug was given to 21 patients (27%), whereas anti-parkinsonian drugs were given to 17 patients (22%). The last two figures are lower than the authors'