the columns

correspondence

L-tryptophan for treatment-resistant depression

L-tryptophan, the amino acid precursor of serotonin, is not widely used as an adjunctive treatment despite its recommendation in treatment-resistant depression (Taylor, 2001).

Perhaps inexperience, limited supporting data (Shaw *et al*, 2002), or the inconvenience of full blood count monitoring and patient registration deter prescribers. Numerous authors have reported on mood changes associated with L-tryptophan depletion (including Bell *et al*, 2001), but few recent studies consider efficacy. We wish to report our experience of L-tryptophan (Optimax) use.

A complete list of patients prescribed L-tryptophan between 1999–2002 under the care of one consultant psychiatrist was obtained from the central Optimax registration service. Fifty-three individuals were identified, of whom 52 case records were available. Response to augmentation as measured on Optimax monitoring forms was recorded (no response, satisfactory, good), along with details of continuation or cessation and reasons for discontinuation.

Thirty-two patients were female, twenty male. The age range was 22–66 (average age 45.4 years).

Twenty-nine patients (56%) reported an improvement in mood following commencement of L-tryptophan (23% satisfactory, 33% good). Twenty-three (44%) reported no response.

Eight patients discontinued L-tryptophan following recovery. Twenty-one discontinued for other reasons: lack of response (ten), reluctance to take L-tryptophan (two), following overdose (one), feeling worse (one), side-effects (six), unspecified (one). The side-effects reported were stiffness (one), irritability (one), dizziness (two), unspecified (two). No patients ceased treatment as a result of developing eosinophilia or symptoms of eosinophilia myalgia. Eighty-six per cent of the patient sample tolerated L-tryptophan.

Although unsophisticated, these results support the use of L-tryptophan as an augmentation strategy in treatment-resistant depression, bringing about symptom improvement in 56% of the sample. This compares favourably to the published 50–60% response rate with lithium augmentation.

BELL, C., ABRAMS, J. & NUTT, D. (2001) Tryptophan depletion and its implications for psychiatry. *British Journal of Psychiatry*, **178**, 399–405.

SHAW, K., TURNER, J. & DEL MAR, C. (2002) *Tryptophan and 5-hydroxytryptophan for depression.* Cochrane Database Systematic Review: CD003198. London: The Cochrane Library.

TAYLOR, D. (2001) *The South London & Maudsley NHS Trust 2001 Prescribing Guidelines*, 6th edn. London: Taylor & Francis.

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Copying letters to patients

I defy any psychiatrist to say that they have not changed the content or nature of their letters with the thought that their patient would be reading what they have written. The change may be conscious or, more interestingly, unconscious. This may reduce the transfer of information to a general practitioner, for example.

While copying letters is most commendable in many ways and well appreciated, I believe that it does fundamentally alter the subtleties of medical correspondence. This does not seem to be addressed in the studies I have seen to date. It is a problem.

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The impact of physical illness and the European working time directives

The article by O'Connor & Vize (*Psychiatric Bulletin*, December 2003, **27**, 443–445) highlights the need, as European working time directives become effective, to optimise the use of medical staff time. In psychiatry, a particular area of difficulty is related to the impact of physical morbidity in old age psychiatry wards on the workload of psychiatry senior house officers (SHOs), especially out-of-hours.

In an East Anglia NHS hospital, we surveyed the referrals (112) received out-of-hours by the psychiatry SHO over a 30-day period, from two 20-bedded psychiatry wards (one old age, one general adult), accident and emergency or other hospital wards. Over 40% were from the old age psychiatry ward, and of these 30 (65%) were for assessment of physical illness. On seven occasions, patients referred for physical problems were found not to be acutely unwell by the psychiatry SHO, and on five, the SHO was called to administer 'nursing' procedures (s/c fluids, heparin, catheter washout) or to organise transfer to medical beds for the administration of blood or IV fluids. Thus, our data suggest that some of these referrals could have been avoided, sparing SHO time for other commitments.

In an attempt to improve the use of SHO time out-of-hours, a voluntary training scheme is being considered at our hospital, which includes the regular exchange of nurses between the old age psychiatry ward and a twinned medical ward. It is hoped that this will result in reciprocal training and 'loan' of specialist nursing skills, at no additional cost for staff or the Trust.

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