Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

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Drug treatment for psychotic depression

I read the review article by Wijkstra *et al* (2006) with much interest as I found the results in the abstract quite striking. However, I wish to raise a few points about the methodology and description of results.

First, the authors have concluded from two studies by Bruijn *et al* (1996) and van den Broek *et al* (2004) that tricyclic antidepressants (TCAs) are more efficacious than non-TCAs in treating unipolar psychotic depression. They have also quoted these studies to state that antidepressant monotherapy is efficacious in treating this disorder. However, both these studies used haloperidol 1–15 mg/day as additional medication during the trial and this would affect the validity of these statements.

Second, the meta-analysis comparing TCAs with TCAs plus classical antipsychotics does not produce a statistically significant result because of the limited number (two randomised controlled trials) and few patients that have taken part in these trials. The overall effect calculated as the relative risk is 1.44 favouring the combination of tricyclics and classical antipsychotics with a confidence interval of 0.86–2.41. The wide confidence interval has affected the statistical significance of these results. However, I think that it is incorrect and possibly misleading for the authors to conclude that they found 'no evidence that the combination of an antidepressant with an antipsychotic is more effective than an antidepressant alone' as the result of the meta-analysis favours the combination and the reason for not obtaining a statistically significant result is the poor quality of constituent studies.

Bruijn, J. A., Moleman, P., Mulder, P. G., *et al* (1996) A double-blind, fixed blood-level study comparing mirtazapine with imipramine in depressed in-patients. *Psychopharmacology*, **127**, 231–237.

van den Broek, W. W., Birkenhäger, T. K., Mulder, P. G., *et al* (2004) A double-blind randomized study comparing imipramine with fluvoxamine in depressed in-patients. *Psychopharmacology*, **175**, 481–486.

Wijkstra, J., Lijmer, J., Balk, F. J., *et al* (2006) Pharmacological treatment for unipolar psychotic depression: systematic review and meta-analysis. *British Journal of Psychiatry*, **188**, 410–415.

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Authors' reply: It is correct that some patients with psychotic depression in the studies by Bruijn *et al* (1996) and van den Broek *et al* (2004) were given haloperidol as adjunctive treatment. However, as mentioned in our article, in our intention-to-treat analysis we counted these patients as having dropped out. So, additional treatment with haloperidol did not affect the validity of our findings regarding patients receiving antidepressant monotherapy.

We agree, as mentioned in our article, that the quality of the constituent studies and the small sample sizes does influence the outcome of our meta-analysis regarding the comparison of antidepressant monotherapy *v.* the combination of an antidepressant and an antipsychotic. But to say that these data favour the combination is statistically not true and surely is no sound basis for contemporary clinical practice to use the combination. Moreover, the data indicate that there is no evidence for the clinical belief that an antidepressant alone is ineffective. Thus, we maintain our conclusion that both antidepressant monotherapy and the combination of an antidepressant and an antipsychotic are appropriate options for patients with psychotic depression.

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Refugee doctors and the development of psychiatry

Cohn *et al* (2006) were perfectly correct to point out the potential of refugee psychiatrists in reducing the recruitment crisis in psychiatry. However, on the basis of the contribution to psychiatry of previous generations of refugees, they also have the potential to contribute significantly to the development of the discipline.

In considering the careers of our refugee colleagues today, we need also to look back to the influx of refugees during the Nazi era, many of whom were hugely influential in the development of psychiatry in Britain from the 1930s onwards. As refugees, they had hurdles to overcome similar to those faced by today's refugees; a new language, the loss of their homelands and, for many, the traumatic deaths of their families. Some are known to have escaped the Nazis at the very last minute, such as Max Glatt (a pioneer in the treatment of alcoholism), Erwin Stengel (remembered for his later work on suicide and attempted suicide and as a professor of psychiatry in Sheffield) and Sigmund Freud. Even in the 1930s, well-qualified doctors from abroad were required to obtain a British medical qualification in order to continue in medical practice.

During the Second World War, some refugees had the further indignity of internment in the Isle of Man as 'enemy aliens'. They included Erwin Stengel, Felix Post (pioneer in old age psychiatry) and the psychiatrist and psychotherapist Adam Limentani. Some, such as Frederick Kräupl Taylor and Felix Post, went into psychiatry aware that their foreign backgrounds would not permit them entry to more popular medical specialties.

Among the refugees was Willi Mayer-Gross, previously a professor of psychiatry in Heidelberg, who also had a distinguished career in Britain; his *Clinical Psychiatry* with Eliot Slater and Martin Roth became a standard textbook. Alfred Meyer became a professor of neuropathology, Joshua Bierer founded the first day hospital in Britain and Michael Balint became widely known for his work on psychological aspects of general practice.

There were women psychiatrists too, such as Liselotte Frankl, Stefanie Felsenberg and Ida Macalpine (psychiatrist and medical historian), as well as others who came to this country as children and