and short answer to the overwhelming needs of patients whose medical symptoms of depression have their roots in alienation, loneliness, or unhappiness in their lives." Unfortunately, as the "former psychiatric patient" rightly emphasises (19 November, p 1351), these treatments are often not "a quick and short answer" in many cases; one wishes this could be so. But when this expatriate refers to "frustration if dissatisfied with psychiatry" Dr Lieberman's point should be noted, that often the life circumstances that he mentions have to be taken into account. These presumably include poor housing or financial circumstances, unemployment, interpersonal conflicts, physical illness, limited intelligence or personality attributes, and many of the other ills that can beset us. The term "unhappiness" is often more appropriate than the clinical description "depression". However, surely the significant qualifying factor is that many of these human problems may only to a limited extent be amenable to help by psychiatrists, in spite of liaison with knowledgeable family doctors, social workers, psychologists, disablement resettlement officers, community doctors and nurses, and housing managers, and the help of marriage guidance councils, clerics, MIND, the Samaritans, day care, home helps, and other agency colleagues.

Let us be practical and acknowledge, as undeniably obtains and is accepted in other medical specialties (with their often less successful cure or improvement rates), that we should not present or infer psychiatry as the panacea for each and every distressing condition. Most of us are only too aware, even when reactive factors are minimal, that reference to, say, an 85% success-response rate does leave an oppressively sad residuum of 15%; they and we have to struggle on. If we are realistic and maintain our integrity by effort and sympathy while thus honestly acknowledging our limitations, then perhaps the credibility gap will narrow and it will be regretfully accepted that we cannot cure even every "pure" psychiatric illness and that we can but do our best with our current techniques. Then, I hope, fewer patients will be "frustrated and dissatisfied." Perhaps we should amend our memos and hospital signs to read "Department of Psychiatry—Limited."

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Perforation of chronic duodenal ulcer during treatment with cimetidine

SIR,—It is likely that an attitude of critical scepticism towards new drugs, maintained by a profession consisting of scientifically inclined practitioners, is to the ultimate advantage of their patients. Such an attitude has become apparent in recent reports of problems encountered among patients taking the H_2 -receptor antagonists cimetidine and metiamide.

We would expect the drug to be most effective in early uncomplicated duodenal ulceration, and adverse reports of four cases have appeared from those engaged in treating such lesions (Dr W A Wallace and others, 1 October, p 865, and Dr B D Keighley, 15 October, p 1022). On the other hand several contributors have recently described problems associated with the use of H_2 antagonists in oesophageal ulceration (Drs M J Gill and

J B Saunders, 29 October, p 1149), erosive gastritis, haemorrhage from gastrojejunal fistula, and gastric ulceration with pancreatitis.¹ To imply criticisms of the drug when it apparently fails in such cases is surely unrealistic.

We wish, however, to draw attention to a more serious indictment of cimetidine. We believe this to be the first report of a patient presenting with perforation of a chronic duodenal ulcer while using cimetidine under medical supervision. After diagnosis of duodenal ulceration with bleeding in January 1977 a 72-year-old man was given a course of cimetidine 1 g daily. His symptoms abated and endoscopy in February 1977 indicated healing of his ulcer. Apart from a six-week break in treatment during July and August, during which his symptoms recurred, the drug was taken continuously and regularly until the present admission. In early October urgent admission was required for epigastric pain which appeared two hours after the nightly dose of cimetidine. At laparotomy a large chronic ulcer on the superior wall of the first part of the duodenum was found to have perforated. Obviously complete relief of symptoms does not necessarily indicate healing of the ulcer, a fact which must be borne in mind by practitioners using these drugs.

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¹ Dudley, H A F, *et al*, *Lancet*, 1977, **1**, 481.

Antidepressants—yes or no?

SIR,—Dr J G Edwards (19 November, p 1327) questions the effectiveness of viloxazine in the treatment of depressive illness compared with placebo. His trial has many implications which suggest that the use of antidepressants needs reviewing. In his study there were more patients on placebo than on viloxazine and more women on placebo than men. Although it is not stated, it looks as though an important proportion of the women on placebo might be under 40 years of age. Raskin *et al*¹ have shown that women under 40 respond better to placebo than to antidepressants. It ought to be added that although some depressed patients might appear to do well on placebo, others will not respond to active antidepressants. "It is therefore important to identify as early as possible, those primary depressives who will not respond to anti-depressant drugs."² They may need other treatment such as electric convulsion therapy (ECT).

An unpublished study of ours, also using the Hamilton and Global clinical scales, with 98 depressed inpatients found no significant differences between amitriptyline, mianserin, and placebo in effectiveness; nor did it show any particular subgroup doing well on antidepressants either on the clinical scales noted or on psychological measures such as the Cattell Clinical Analysis Questionnaire. Similarly, Dr Edwards's trial does not show if any clinical age group does better on antidepressants than on placebo. For these reasons and others previously stated³ there is a need to examine closely antidepressant trials and not to close discussion about the effectiveness of antidepressants. For example, Rogers and Clay⁴ found that imipramine was of undoubted value

for treating acute endogenous depression. Maxwell,⁵ looking at the same paper, also felt (as did we) that there was further need for trials that included a placebo in establishing the place of antidepressants.

It is interesting that in the same issue of the *BMJ* Dr Lieberman (p 1355) rightly points out that medication is used as if it would provide a quick and short answer to patients whose symptoms have their roots in unhappiness and various environmental factors. In other words, is it only a small proportion of depressed patients who are suffering from endogenous depression? Perhaps relief from symptoms is less dependent on the actions of antidepressants or placebo and more on "natural causes," as suggested, again in the same issue, by a "former psychiatric patient" (p 1351), while Mr A J Cooper (p 1358) notes the "Catch 22" situation in which L-tryptophan is an antidepressant when prescribed in tablet form but is classed as a food and not as a drug when prescribed as a powder.

If to these reservations are added other controversies concerning the nature of depression and its treatment (for example, ECT) it seems clear to us that this is one of the most important problems requiring clarification, particularly for the treatment of individual patients. After 40 years the use of ECT is being more and more frequently questioned. It is to be hoped that 40 more years do not go by before we can clearly say yes or no about the effectiveness of antidepressants.

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¹ Raskin, A, *et al*, *Archives of General Psychiatry*, 1970, **23**, 164.

² Davidson, R T, *et al*, *British Journal of Psychiatry*, 1977, **131**, 403.

³ Kerry, R J, and Orme, J E, *British Journal of Psychiatry*, 1976, **128**, 510.

⁴ Rogers, S C, and Clay, P M, *British Journal of Psychiatry*, 1975, **127**, 599.

⁵ Maxwell, C, *British Journal of Psychiatry*, 1976, **128**, 510.

Further experience with primary excision of brain abscess

SIR,—Mr J S Garfield and Mr A J Keogh, (19 November, p 1349) restate yet again the time-honoured arguments in favour of conventional burrhole drainage for brain abscess. This method has, we believe, been discredited by paper after paper in which poor results have been reported; the bibliography of our article (29 October, p 1119) contains many of these.

It is perfectly obvious that the computerised tomographic scan is clearly superior to all other forms of investigation in this disease, and the method is used wherever and whenever it is available. In our hands it has provided an excellent guide for immediate primary excision, demonstrating clearly multiple loculi and daughter abscesses which are simple to excise but notoriously difficult to tap or drain.

The policy in this centre for management of brain abscess is now immediate excision and we should like to take the opportunity to report a further eight consecutive cases so treated with excellent results, no deaths, and no morbidity. Thus, although our original series was small, our conclusions have been amply born out by further experience. Three were deeply unconscious patients (two