Use of antidepressants in schizophrenia

SIR,—Your leading article on the use of antidepressants in schizophrenia (12 April, p 1037) drew the conclusion that, since chlorpromazine seems to be as effective in depression in schizophrenics as chlorpromazine combined with amitriptyline, the value of antidepressants even for schizophrenics with undoubted depression has yet to be firmly substantiated. Surely you have ignored the evidence from at least three trials¹ that chlorpromazine is as effective an antidepressant as imipramine even although it is not usual clinical practice to employ chlorpromazine as such.

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¹ Davis JM, Janowsky DS. *Br J Hos Med* 1974; Feb 219-28.

*.*Chlorpromazine and other phenothiazines may indeed have an antidepressant effect in their own right, a point that could usefully have been made in our leading article. This, however, only emphasises the difficulty of establishing, even for those schizophrenics with definite depression, that conventional antidepressants are of value. Moreover, it is not clear whether neuroleptics help depressive symptoms in schizophrenia by acting on the basic schizophrenic process or whether they act on the depressive symptoms by a separate mechanism.—ED, *BMJ*.

Fusidic acid and jaundice

SIR,—In view of the occasional reports of favourable response to sodium fusidate (Fucidin) in patients with psoriasis a double-blind cross-over trial of systemic sodium fusidate 1.5 g a day was undertaken in 33 patients. Patients were examined at two-weekly intervals for 12 weeks and no significant clinical changes were noted between sodium fusidate and placebo. During this trial liver function tests were among the parameters monitored. This study enabled us to compare the effect of over 80 g of sodium fusidate over eight weeks (17 patients) and an identical dose of lactose-containing placebo (16 patients) on liver function. No such comparative data have ever been published and they are therefore of interest in the light of the recent observation by Dr M W Humble and others (21 June, p 1495) on the association between therapy with fusidic acid and the development of a reversible jaundice.

Liver function tests—specifically the total serum bilirubin, alkaline phosphatase (AP), aspartate transaminase (AST), and alanine transaminase (ALT)—were determined before treatment and after both four and

eight weeks' therapy. The number of patients with values which were above the normal range for this hospital are shown in the accompanying table. Neither sodium fusidate nor the lactose-containing placebo had any marked adverse effect on our measures of liver function.

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SIR,—It was with considerable interest that I read the recent account by Dr M W Humble and others (21 June, p 1495) of jaundice in association with intravenous fusidic acid (Fucidin) therapy. The evidence for this important complication, though circumstantial, appears overwhelming. Nevertheless, it was interesting to note that the jaundice was reversible and, despite the high incidence of jaundice in patients with staphylococcal septicaemia treated with fusidic acid, the overall mortality was actually lower in this group than in those treated with other antibiotics. This was despite some suggestion that a greater number of the seriously ill patients received fusidic acid.

In common with other orthopaedic surgeons, I have found fusidic acid, especially when combined with flucloxacillin or a cephalosporin, to be quite invaluable for controlling and even curing chronic staphylococcal osteomyelitis. In this situation oral therapy may be required for up to six months and I personally have yet to encounter a serious side effect.

Even longer-term exposure to constant low doses of the antibiotic may occur when it is incorporated in bone cement. A prospective randomised trial of antibiotics in bone cement has been conducted at Kingston Hospital, Surrey, during the past four years. In a total series of 500 patients, 250 have so far received 500 mg of fusidic acid incorporated into each 40 g pack of their bone cement but have so far failed to show any serious complication.

While agreeing that intravenous fusidic acid must be used with caution, I trust that this report will not cause one of the safest and most reliable antibiotics in my armamentarium to fall into ill repute.

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SIR,—We were interested to read the paper by Dr M W Humble and others (21 June, p 1495) concerning jaundice in patients given fusidic acid. We also have some evidence that fusidic acid, and the oral form sodium fusidate, may

produce jaundice. Since 1976 the West Midlands Adverse Drug Reaction Study Group has received six reports. In five of these jaundice occurred in patients on oral sodium fusidate, and in one it was associated with intravenous fusidic acid. As with many reported adverse reactions, a causal relationship could not be established with certainty. However, in all six cases the jaundice occurred a few days after starting the drug and resolved when it was discontinued. Full details were obtained for five of the cases. Three had normal liver function tests before treatment and no other cause was found for their jaundice. Two had abnormal liver function tests before treatment, but in both the bilirubin increased progressively while they were on the drug and returned to previous levels when it was stopped. Two of these cases have been briefly described elsewhere.¹

Between 1963 and February 1980 the Committee on Safety of Medicines received 116 adverse reaction reports concerning Fucidin; 44 of these (including our six) were reports of jaundice (Committee on Safety of Medicines, personal communication).

We agree with Dr Humble and his colleagues that jaundice due to fusidic acid is not mentioned in many reviews of drug-induced liver disease and we hope that their paper will draw more attention to this possible adverse effect. We report our cases not to discourage the use of a valuable drug but in the hope that awareness of this effect may assist in the differential diagnosis of jaundice in patients receiving fusidic acid or sodium fusidate.

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¹ Mantel A. In: Dukes MNG, ed. *Side effects of drugs: Annual 4*. Amsterdam: Excerpta Medica, 1980:198.

What is "emergency"?

SIR,—Mr E P Abson (21 June, p 1356) takes us to task for perpetuating the Platt Report's misconception of the word casualty.

The Platt Report¹ first defines the word as meaning severe injury or death caused accidentally, and says it was so used by Shakespeare. This meaning is confirmed by the Oxford Dictionary. The report gives a second meaning as denoting a department in the hospital where a certain kind of outpatient is treated. It dates this use from the second half of the nineteenth century. The source quoted is a report from the *Lancet* in 1869.² This explains that in St Bartholomew's Hospital, London, outpatients were divided into proper outpatients and casualties. Casualties "comprise those who are supposed to require temporary treatment for diseases or injuries of a trifling character." The Oxford Dictionary confirms this meaning also, and quotes from the annual report of St Bartholomew's Hospital of 1885. The Platt Report was concerned that in the public mind there was confusion between casualty and casual patients. In 1869 the patients designated as "casualty" at St Bartholomew's were described as "casual minor medical" and "casual minor surgical" at Guys.³ It is not surprising that there has been some confusion.

Mr Abson may well be correct that from the sixteenth to the twentieth centuries the term casualty was not a substitute for accident and

Patients on sodium fusidate and on placebo with values above normal range in liver function tests

	Sodium fusidate			Placebo		
	Pretreatment	4 weeks' treatment	8 weeks' treatment	Pretreatment	4 weeks' treatment	8 weeks' treatment
Bilirubin	1	1	0	1	0	1
AP	2	2*	0	1	0	3†
AST	1	0	0	0	1*	0
ALT	3	3*	0	0	0	0
No of patients with raised values	4	4†	0	2	1*	4†

*One patient had a normal value before treatment.
†Two patients had normal values before treatment.

emergency. However, in the past 18 years in medical circles the term accident and emergency has come to designate precisely what previously had been called casualty. This stems directly from the Platt Report's second recommendation. In the ensuing years it has gained such widespread acceptance in the United Kingdom that one searches with difficulty for any trace of the word casualty in an authoritative contemporary document on this subject such as the Lewin Report,⁴ where it appears briefly on page 23, referring to small peripheral departments, but where in all other paragraphs the term accident and emergency is used.

Maybe the discussion on page 4 of our book⁵ on the use and misuse of accident and emergency departments does lack the clarity and forcefulness which Mr Abson desires. However, I cannot believe that clarity and forcefulness would have been well served by substituting the word casualty for either "emergency" or "accident and emergency," or by defining casualty in terms of "community dependence" described as "the need of immediate assistance from the independent citizen."

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¹ Subcommittee of the Standing Medical Advisory Committee of the Central Health Services Council. *Accident and emergency services*. London: HMSO, 1962:23-4, 39. (Platt Report.)

² Anonymous. *Lancet* 1969;ii:577.

³ Anonymous. *Lancet* 1969;ii:613.

⁴ Lewin W. *Medical staffing of accident and emergency services*. London: Joint Consultants Committee, 1978:23.

⁵ Rutherford WH, Nelson PG, Weston PAM, Wilson DH. *Accident and emergency medicine*. Tunbridge Wells: Pitman Medical, 1980:4.

Open-access endoscopy

SIR,—Mr M W L Gear and others (3 May, p 1135) justify their open-access endoscopy service by their success in finding organic lesions. A cynic has defined a healthy person as "someone who has not been fully investigated." Their article does not show the effect of the investigation on the patient or how relevant they considered, for example, the mucosal lesions.

Gastroenterologists find that many dyspeptics have no relevant organic lesion and are cured by instant reassurance supported, when necessary, by barium meal or endoscopy. These have suffered in the past from being wrongly labelled as victims of visceroptosis, chronic appendicitis, chronic cholecystitis, or hiatus hernia (without objective evidence of reflux). Obviously, the endoscopist will find more satisfaction in "finding something"; but much mucosal disease like gastritis is irrelevant and found in normal people, or a reddened mucosa may be a reaction of the psyche to endoscopy. If an unnecessary organic label is given, neurosis may be perpetuated and patients may be condemned to dieting or cimetidine instead of being cured by reassurance.

So open-access endoscopy can do harm. The ill effect of new technology has been shown in other specialties; for example, the electrocardiogram produced many invalids in the early days before the normal variations were known.

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Low-tar smoking versus middle-tar smoking

SIR,—Dr M A H Russell and others (5 April, p 972) report an important study which, albeit in a highly selected population, indicates that smokers of ventilated (low-tar) cigarettes smoke their products more intensively than smokers of unventilated (middle-tar) cigarettes when the products have been both self-selected and smoked over a relatively long period of time.

The results presented, however, based primarily on the measurement of blood nicotine, do not wholly support the authors' conclusion that tar intake is not appreciably lower in the low-tar smokers than in middle-tar smokers. Despite a high (statistical) correlation between the tar and nicotine yields of manufactured cigarettes the tar:nicotine ratio can by no means be considered a constant. On the basis of table IV of the paper the middle-tar and low-tar products have, on average, tar:nicotine ratios of 13.77 and 11.63 respectively. Thus even if smokers achieved the same levels of nicotine from the low-tar cigarettes as from the middle-tar cigarettes, their tar intake would remain on average lower by 16%. In fact, the levels of blood nicotine measured in the low-tar cigarette smokers are for men 87.5% and for women 95% of the values found in the middle-tar cigarette smokers; on the basis of these levels the corresponding relative tar intakes would be 73% for men and 80% for women (one would expect a relative nicotine intake of 62% and a relative tar intake of 52% if the cigarettes were smoked under comparable standard conditions). Therefore although the nicotine intake by low-tar cigarette smokers may not be appreciably lower than that of middle-tar cigarette smokers it does not follow that the same is true for tar intake.

It might be argued that this could support the hypothesis that has been advanced that maintenance of nicotine intake determines the intensity of smoking but whether this is true or not, the smoker—if he cannot stop smoking—should be encouraged to smoke not only a lower-tar product but also one with a lower tar:nicotine ratio.

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Carbon monoxide yield of cigarettes

SIR,—Dr N J Wald and Sir Richard Doll disagreed with Mr P N Lee's statement that there seems to be no strong case for the publication of carbon monoxide (CO) yields on the grounds that the values would be useful to physicians who wish to advise smokers to reduce their exposure (1 March, p 646). We question the general assumption that numbers for quantities such as cigarette tar, nicotine, and CO are a good indication of potential brand toxicity.

Estimations for cigarette yields are provided by smoking machines, which take a 35 ml puff of two-second duration once every 60 seconds until a fixed butt length is reached. These conditions are probably a poor reflection of current human behaviour, particularly for those smokers who "compensate" when they switch brands¹; as Drs M J Jarvis and M A H Russell point out in their comment on the Hunter Committee's second report (5 April, p 994), there is much evidence that people do

not smoke cigarettes in the same way that smoking machines do.

The utility of these standard numbers may be questioned on other grounds as well. The Canadian Government has recently released the CO yields of cigarettes and, on the basis of these results, we have defined a group of low-hazard cigarettes, average CO yield 10.9 mg (range 1.7 to 14.8 mg), and high-hazard cigarettes, average CO yield 23.0 mg (range 20.7 to 24.4 mg).² We have also determined levels of carboxyhaemoglobin for two groups smoking similar numbers of both types of cigarettes ("low" 19±2 and "high" 19±3 cigarettes per day) and found no difference. The average for smokers of the "low" CO yield brands was 4.7±0.8% and 5.0±0.8% for those smoking the brands defined as "high" yield. If this result is substantiated by further studies, then it would be difficult to escape the conclusion that behavioural factors are far more important than cigarette yields in determining exposure and the risk of smoking-related diseases. Obviously in order to answer this question CO yields must be made public.

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¹ Schulz W, Seehofer F. In: Thornton RE, ed. *Smoking behaviour, physiological and psychological influences*. Edinburgh: Churchill Livingstone, 1978:259-76.

² Rickert WS, Robinson JC, Young JC. *J Toxicol Environ Health* 1980;6:353-67.

A computer in every surgery?

SIR,—The leading article "A computer in every surgery?" (28 June, p 1556) is in our opinion a retrogressive contribution to the debate on the role of computers in general practice. It fails to recognise the very real changes in record keeping which have occurred over the last few decades in a large number of practices. It fails to recognise the importance of information systems to assist practice management, the process of care, surveillance of chronic conditions, and clinical audit. It fails to recognise the rapidly changing world in which we live and, finally, it fails to recognise the far-reaching changes in general practice which will have to materialise if the GP is to retain his position as the main provider of primary care.

It is just not possible for the general practitioner's surgery to remain a haven from modern society. Our role in society is largely determined by our patients and we ignore their needs and wishes at our peril. A recent example of our failure to meet this need is over the matter of blood pressure measurement. We inform the public that untreated high blood pressure leads to an increased chance of a stroke, yet we deny them the opportunity to receive regular blood pressure checks because we are too busy for routine screening procedures. Our patients, therefore, turn to the supermarkets and chemists where a machine takes their blood pressure. If we do have to resort to such a machine to take blood pressures, then surely it should be situated in the doctor's surgery. With an increasing awareness of risk factors, and the need for informed advice for all patients, including the obese, smokers, and women over 35 years taking the contraceptive pill, the GP who does not record these facts and advise his