antidepressants (and in four cases also to electroconvulsive therapy). They came from a series of 59 consecutive referrals to a catchment psychiatric service meeting and met the International Classification of Diseases (revision 9) criteria for manic depressive illness (37) or depressive neurosis (22). Systematic comparisons between lithium treated subjects, those who responded to tricyclic antidepressants (18), and others who failed to respond to tricyclic drugs (9) showed no significant demographic differences, although delusions were more common in the lithium treated group (5/9) than the other group of non-responders (1/9; $p < 0.01$). Lithium augmentation was successful in six of the nine patients. In two cases lithium had to be discontinued because it was poorly tolerated, and one patient failed to respond despite an adequate trial of lithium. At follow up (median 6 months, range 3 to 20 months) seven of the nine subjects in the lithium treated group were well. This was similar to the outcome in those who responded to tricyclic antidepressants (14/18) and significantly better than that in the other non-responders (0/9; $p < 0.01$).

We conclude that lithium augmentation is a relatively well tolerated treatment manoeuvre in refractory depression in old age and may be of particular use in delusional depression and when electroconvulsive therapy has failed. We are planning a prospective trial of lithium augmentation in the elderly.

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SIR,—Dr Bob Baldwin has made a good case for an aggressive approach to the treatment of late life depression (20 February, p 519). He suggests that the cardiotoxic effects of tricyclic antidepressants have been exaggerated. This may perhaps be so in patients who are depressed without associated cognitive dysfunction, but dementia and depression often overlap and many patients will be prescribed antidepressants. Our observations from a recent study¹ suggest that, at least in this group, care must be exercised in prescribing tricyclics, not because of their cardiotoxic potential but because of their potent anticholinergic activity.

Thirty seven patients with dementia or depression, or both (mean age 79 years; 16 women), were diagnosed on *Diagnostic and Statistical Manual-III* criteria and assessed using the Hamilton rating scale for depression and Sandoz clinical assessment-geriatric rating scale. All patients with clinically important depression and those with positive results with a dexamethasone suppression test were treated with full therapeutic doses (150 mg/day) of amitriptyline for up to three months, after which the clinical assessments were repeated. All adverse reactions were recorded throughout the study.

The response to antidepressant treatment was variable: only four of 23 patients prescribed amitriptyline showed an improvement of their depressive symptoms. Among the remaining 19 the treatment had to be stopped within two weeks in five and by the end of four weeks in three more because of adverse reactions. The reason for termination of treatment was a deterioration of mental state in seven patients (five developed confusion and agitation, two increasing agitation,

and all showed a global deterioration of dementia score). Five others developed the usual anticholinergic side effects such as dryness of mouth and problems with micturition, and two became incontinent. Six showed minor electrocardiographic changes but these were clinically unimportant. In five the symptoms of confusion and agitation improved within two weeks of stopping medication.

These findings suggest that patients with dementia, with or without depression, show poor tolerance for tricyclic antidepressants. The mechanism of this deterioration of cognitive functions is not clear. Cholinergic mechanisms have been implicated in the aetiopathogenesis of dementia, and several reports have shown a deficiency of acetylcholine in the brains of elderly dementing patients.^{2,3} Anticholinergic activity also appears to relate to clouding of consciousness.⁴ All tricyclic antidepressants have an intrinsic anticholinergic activity and this action may worsen the precarious balance of cholinergic mechanisms in the brains of dementing patients, causing an aggravation of acetylcholine deficiency. The contribution made by the hypotensive effects to the clinical deterioration seen in these patients is not clear, but it is unlikely to be a major factor since serious falls in blood pressure were not detected.

These observations have important implications for the management of patients with dementia who may also have an affective disorder. Since tricyclic antidepressants are less likely to be tolerated by these patients their use in clinical psychiatry needs to be tempered with caution.

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Hypnotic drug use for the elderly

SIR,—Benzodiazepines share the same pharmacological effects and create the same problems whether described as hypnotics or anxiolytics. It is often convenient, therefore, to ignore these two therapeutic categories and refer generically to "tranquillisers" or "sedatives." While usefully emphasising similarities, however, these terms can also obscure some important differences.

In both Dr P Tyrer's leading article (27 February, p 588) and the paper by Dr E K Rodrigo and others (27 February, p 603) there is, for example, an implicit assumption that the use of benzodiazepines should necessarily be mediated by psychiatric disturbance. Thus while the symptom of anxiety is given prominence in both articles the topic of sleep is mentioned in neither. This assumption may be valid for younger people but is unlikely to be valid for the elderly. Long term hypnotic drug use in old age is directly related to the sleep problems experienced by that age group, and these problems are often somatic in origin.¹ One of the clear implications of our own paper (27 February, p 601), and that of Rodrigo and others, therefore, is the need for a broader, more flexible clinical response to complaints of poor sleep in later life—a response which includes assessment, education, counselling, and the involvement of other agencies, particularly clinical

psychology. Unfortunately, this implication is easily overlooked if the problems of long term "tranquilliser" use are discussed only in terms of daytime anxiety management and presumed psychiatric disturbance.

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SIR,—Dr Kevin Morgan and colleagues (27 February, p 601) report a significant increase in the prevalence of hypnotic drug use with age. However, they include antidepressants as hypnotic drugs and I note that 9% of users were taking antidepressants.

The Liverpool longitudinal community survey of health among the elderly used standard interviews to gather a wide range of information, including data on drug use in the month before interview.¹ Data are now available from both the initial survey (1982-3) and the three year follow up. When the use of benzodiazepine hypnotic agents was analysed 8.8% (94) of the 1070 people surveyed in year 0 and 11.9% (83) of the 695 surveyed in year 3 were found to be users and, like Dr Morgan and colleagues, we found a significant excess of women. There was, however, no significant increase in use with age within the two study years, although there was a higher proportion of very elderly users in year 3 than in year 0 (table).

Age distribution of hypnotic users

Age range	% Of sample	
	Year 0 (n=1070)	Year 3 (n=695)
65-74	8.4	10.8
75-84	10.5	13.6
≥85	5.4	10.6

Using a log linear model: χ^2 year $\times$ age $\chi^2 = 8.15$, $df = 2$, $p = 0.017$; χ^2 age $\chi^2 = 4.53$, $df = 2$, $p = 0.104$.

The prevalence of both depressive psychosis and neurosis increase sharply in those aged 79 and over,¹ and, although general practitioners recognise depression in the elderly, they do not always treat it effectively.² By including antidepressants among hypnotic drugs (and respondents may perceive sedative antidepressants prescribed primarily for depression as drugs prescribed to promote sleep) Dr Morgan and colleagues may be reporting an increase in hypnotic use with age. This may be partly due to an increasing prevalence of depression with age which is being recognised and treated.

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Providing donor organs for transplantation

SIR,—Transplant surgeons and, more especially, our patients are indeed most grateful for the efforts made by Mr P Richards (27 February, p 642) and other neurosurgeons, anaesthetists, and intensivists in approaching relatives at the time of bereavement to allow provision of organs for transplantation.

We do endeavour always to send letters of thanks to all concerned. The efficacy of transplantation for all organs is widely reported in the medical press and we lecture frequently and regularly on all aspects of transplantation, including the management of organ donors, throughout Britain. We would be only too happy to lecture in Mr Richards's unit. As far as the general media are concerned it is important to remember that transplantation is unique in medical practice in that organs are donated from the general public at a time of acute personal distress in order to help an anonymous recipient. Unlike the medical profession, the only way the public can see the results, problems, and benefits that can arise from transplant activity is through responsible media coverage.

We endeavour always to fit in with the plans and timings set by referring hospitals in conjunction with the other transplant teams but consider statements such as the one made by Mr Richards that "he" specifies a time by which the procedure must be completed, and if the transplant teams cannot fall in with that time then they will miss out on the organ, are selfish. All concerned in transplantation should realise that this attitude does not deny the transplant surgeon an organ but a potential recipient the opportunity to receive an organ and to improve their quality and quantity of life.

The heart must function immediately on implantation, and current preservation techniques provide a maximum ischaemic period of about four hours. The time taken in the organ procurement procedure therefore determines the time in which the implantation must be performed. Not only do arrangements have to be made for the procurement procedure but also the recipient must be transported to the transplant centre, often from long distances such as Scotland and Northern Ireland, and be prepared for surgery so that the heart can be transplanted immediately on its arrival.

When appropriate we would welcome early referral of potential donors after initial tests have confirmed the absence of brain stem function. This would help both ourselves and the donor hospitals with their plans, and we ask that referring hospitals do not make unreasonable demands on the transplant centres so that this scarce resource can be used to maximum benefit.

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SIR,—As transplant coordinators we agree with Mr P Richards that it is wrong and counter productive to continually blame intensive care unit staff for the lack of donor referrals (27 February, p 642). The BBC *That's Life* programme on transplants on 10 January 1988 failed to emphasise the difficulties intensive care units are facing with closed beds and staff shortages and also that brain death is an infrequent event in many district general hospitals.

Little coverage has been given to the role of the coordinator in Britain. Most of us provide support and practical help throughout the donor referral process to the relatives and staff. A letter of appreciation is always sent to relatives and the staff concerned. Many relatives continue to keep in touch with us long after donation. When consent has been given to organ donation it is our responsibility to carry out the wish of the patient and relatives, ensuring that organs are used. It is not our experience that the procedure is delayed through transplant teams, but it is frequently delayed through lack of available theatre facilities.

New guidelines on care and related issues have

been issued nationally by the Transplant Coordinators Association. They should be available in all intensive care units. Our job is very active and we are therefore unable to agree with many of Mr Richards's comments.

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Do psychiatric registrars take a proper drinking history?

SIR,—Drs M P Farrel and A S David report deficiencies in drinking histories taken by psychiatric registrars working at the Maudsley Hospital (6 February, p 395). In a recent retrospective audit of an acute (disturbed) admission ward in a teaching hospital the findings were similar. The case notes of 30 patients admitted consecutively to the ward were scrutinised. These notes contained full records of 60 admissions, which had been clerked by seven psychiatric trainees. In seven cases there was no mention of drinking history, in 12 a qualitative account was recorded, and in 11 quantitative information was obtained.

The explanation for these findings may be of interest. Nineteen of the 30 patients had detailed and comprehensive histories; of the remainder, nine had severe functional psychoses, one was mentally handicapped, and one had a dementing illness (previously diagnosed in another hospital as Huntington's chorea). During these admissions it was very difficult to obtain histories of adequate detail from the patient; accounts from other people were limited or absent. Two of the functionally psychotic patients were transferred to other hospitals and may have been more competent at a later stage; two discharged themselves from hospital.

We agree that a history of alcohol intake is essential as part of the routine assessment of psychiatric inpatients. These data, however, suggest that this may sometimes be difficult to obtain. Trainees should be encouraged to return to this subject later in the admission; full histories from relatives and friends are often crucial, although in shifting inner city populations they are not always available. In a small number of the most disabled patients it may never be possible to achieve an adequate history.

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Acheson: a missed opportunity for the new public health

SIR,—The Acheson committee had as its focus the future development of the public health function. Its specific remit concerned the specialty of community medicine but also the need for improvements in effectiveness and efficiency.¹ This included the best use of existing resources, and Dr John Ashton (23 January, p 231) has correctly criticised the report for not allying community medicine with those engaged in promoting public health outside the NHS. It is also a matter for regret that groups within the NHS have been left out of the committee's plans—notably community paediatric doctors.

Child health doctors are substantial in number (community health service medical staff, most of whom are engaged in child health, take up 2347 whole time equivalents compared with 779 for community medicine²). They are an increasingly

effective group representing a powerful blend of experience and enthusiasm—more mature doctors combining with an infusion of younger paediatricians. Training schemes are increasing³ and both older and younger doctors are moving into consultant community paediatric posts.

Community paediatrics deals with many aspects of public health relating to children—immunisation, developmental surveillance, and health education in clinics and schools. Unless this contribution is taken into account confusion will arise at district level. Does the chairman of a local authority education committee turn to the director of public health or to the consultant community paediatrician responsible for the school health service? Similarly, who should a social services chairman contact over child abuse? Particular problems will arise over immunisation and infectious disease. Individual community paediatricians are responsible for immunisation in some districts. Would the proposed control of infection officers take over their role? When a serious infection occurs in a nursery or school will the attached child health doctor be involved or not? Since so many outbreaks of infectious disease affect children it would seem sensible to have a community paediatrician as well as a general practitioner on a district control of infection committee.¹

Regrettably, the contribution of community paediatricians to the public health is not considered in the Acheson report. Powerful teamwork is possible if the proposed public health specialists are made aware of the legitimate contribution of their community paediatric colleagues. If not, the present confusion over who is responsible for child health in the community will only worsen.

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SIR,—Dr John Ashton (23 January, p 231) was critical of the Acheson inquiry but I believe that its recommendations would go far in improving the organisation and morale of those working in public health medicine. With concern increasing about the performance of the National Health Service the recommendations should be quickly implemented.

The report emphasises the importance of health services research. One of the greatest disappointments since the development of community medicine in 1974 has been the limited amount of health services research undertaken. Reductions in staff funded by the University Grants Committee in some academic departments are another reason for lack of progress. Some difficulties in health service research are outlined in the report, but para 8.22, which criticises the quality of applications, could be misleading. The practical nature and time scale of health service research requirements are different from those of other epidemiological research. Close collaboration and agreement with other health professionals are needed, and appropriate timing is all important. Opportunities often arise at short notice and advance planning is often difficult. For this reason the usual methods of seeking research funds are sometimes inappropriate. Reviewing the literature and writing a scientific