Editorial

David Taylor

We don't hear much about MAOIs (monoamine oxidase inhibitors) these days, but they retain a place in therapy, usually for refractory or atypical depressive illness. Thirty or forty years ago MAOIs were the SSRIs (selective serotonin reuptake inhibitors) of their day, being widely prescribed by GPs and psychiatrists. More latterly they found a place in combination with tricyclics as a treatment of choice for refractory depression. This combination was used only by specialists who were well aware of the dangers of such combinations and who carefully avoided the use of tricyclics with potent effects on serotonin reuptake (clomipramine and amitriptyline for example). Official guidance suggested separating the administration of tricyclics with MAOIs by two weeks in order to avoid potentially fatal adverse reactions. This is because MAOIs permanently inhibit monoamine oxidase and function only recovers as new enzyme is synthesised – a process thought to take up to two weeks. In this issue Sarah Yates and colleagues describe a case of adverse interaction (in the form of serotonin syndrome) occurring when the SNRI venlafaxine (a potent serotonin-norepinephrine re-uptake inhibitor at low doses) was given two, four and ten weeks after stopping the MAOI phenelzine. The authors also expose the near absence of data on monoamine function recovery after MAOI cessation – undoubtedly a legacy of the long-ago period in which MAOIs were developed. Their report serves an important warning that manufacturers' recommendations do not always assure safety, especially if those recommendations were drawn up forty years ago.

Antipsychotic depots were developed some time ago, too and saw their heyday in the 1980s.

Their use has always been constrained by concerns about a higher risk of inducing tardive dyskinesia and by rather complex and often poorly characterised pharmacokinetics. The latest depot antipsychotic to be introduced is paliperidone palmitate – an atypical drug (it is the major metabolite of risperidone) with a well-studied pharmacokinetic profile. In practice, all patients receive a 'loading' dose of 150 mg on day 1 and then 100 mg on day 8. This dose regimen assures therapeutic plasma levels are achieved in all patients within a few days. The maintenance dose can then be adjusted in the range 50–150 mg a month according to response. However, this imperative of 'one dose for everyone' (at least to begin with) is rare in psychiatry, where individualisation of dosing is the norm. So, it inevitably raises questions about tolerability and about suitability for all patients. Also in this issue, Cynthia Bossie and co-workers examine the tolerability of these doses of paliperidone palmitate in patients recently diagnosed with schizophrenia – the group of patients most vulnerable to adverse effects. In fact, tolerability was remarkably good – only injection-site pain, agitation and headache were more common with paliperidone than with placebo in the first week. After this time, the frequency of adverse events was only slightly higher than placebo. This is useful and reassuring information to have when a formulation is first introduced.

Another new concept to psychiatry is medicines reconciliation – the process of assuring that the medicines a patient receives before admission are the same as those prescribed on admission. Carol Paton's UK study shows that the process

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is quite widespread in psychiatry and that it identifies a large number of errors — around a quarter of in-patient prescriptions were not in accordance with pre-admission prescriptions.

So, new observations on old drugs, better understanding of new drugs, and new processes in the practice of psychiatry — all broadly representing therapeutic advances in psychopharmacology and each usefully contributing to clinical practice.