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Authors' reply: We were delighted to read that our paper was so enthusiastically discussed by Sridharan *et al* at their evidence-based journal club. They have spotted the main limitation to the study, which was included in our own list of limitations – namely, that our findings were "based upon only one service model and may have limited generalisability" (Sipos *et al*, 2001). In our paper, we cited previous work from Nottingham (Harrison *et al*, 1991), showing how the development of multi-disciplinary teams had coincided with a reduction in the proportion of patients with first-episode psychosis requiring hospitalisation at initial contact. In Sipos *et al* (2001) we went on to show that, although there is clearly a reduction in hospitalisation at first contact, the risk of admission at some point in the first 3 years after first onset has actually remained the same. Indeed, there are striking differences between those patients admitted early in the course of the disorder and those admitted later.

On reflection, we agree that the paper would have benefited from a slightly more detailed specification of service changes in Nottingham, although these have been described elsewhere and we would refer readers to Beck *et al* (1997). We would caution, however, against attempts to draw causal inferences from the presence, or absence, of particular 'community' services because our paper reported an observational study rather than a controlled one. The research community has barely begun to understand the interplay between different components of 'community-oriented' services and patient outcomes. The parameters mentioned by Sridharan *et al* are certainly pointers in the right direction but we have some way to go in describing (and measuring) factors such as the amount of 'social support' available, let alone evaluating their impact on outcomes.

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Antipsychotics and risk of venous thrombosis

The article by Thomassen *et al* (2001) relates a higher risk of venous thrombosis to the use of antipsychotic drugs. As mentioned by the authors, their data cannot consequentially link the risk of venous thrombosis to antipsychotic use as certain biases cannot be excluded from the autopsy date and case–control studies they analyse. However, their study adds to the numerous reports suggesting a link between this class of medication and venous thrombosis. In this debate, however, it should be noted that there is a lack of controlling for factors such as the dose of antipsychotics and the type of psychosis. Catatonia is typically a form of schizophrenia in which one could expect patients to have a higher risk of venous thrombosis (Morioka *et al*, 1997). Similarly, according to the dose of antipsychotic, the sedation of patients can be so intense that their movements are limited, creating predisposing conditions for venous thrombosis. It is possible that more cautious administration of antipsychotics at a dose which decreases the psychotic symptoms without inducing toxic sedation (Casey, 1997) could prevent a certain number of thrombosis cases, although low doses of antipsychotic appeared paradoxically associated with higher risk in a recent case–control study (Zornberg & Jick, 2000). Exploring the role of these potential confounding factors, particularly in cohort studies, is important to characterise the safety profile of antipsychotic drugs and to improve guidelines for the treatment of patients with psychosis.

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Use of antidepressants by nursing mothers

Hendrick *et al* (2001) state that the findings of their study provide no reason to discourage nursing among women taking paroxetine, fluvoxamine or sertraline at standard therapeutic doses. Comparison with previous studies is difficult, owing to the research literature consisting mainly of single case reports or small samples, difference in methods and lack of key information (as reviewed by Yoshida *et al*, 1999).

While I applaud the effort of studying 50 nursing mother–infant pairs, I disagree with the inclusion of all of them as study subjects for two main reasons.

First, seven were included whose prescribed doses of antidepressant were below the recommended dose (British Medical Association & Royal Pharmaceutical Society of Great Britain, 2001) for the treatment of depression (paroxetine 5 mg (n=1), paroxetine 10 mg (n=2), sertraline 25 mg (n=4)). In the case of sertraline, where 30 pairs were included, exclusion of these subjects would increase the percentage of detection of medication, including metabolites, from 24% (8/30) to 34% (8/26).

Second, Hendrick *et al* came to the same conclusion regarding the safety of fluvoxamine, sertraline and paroxetine, but according to their Table 1 (p. 164) only one serum sample of the five taken from mother–infant pairs where the mother was taking fluvoxamine should be taken into consideration. Of the remainder, no maternal medication concentration was obtained in three cases, and in the fourth maternal medication concentration was below the detectable range of the assays, raising

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