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Correspondence

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Antipsychotics and borderline personality disorder

I congratulate Lieb *et al* on their excellent systematic review.[1] However, it is interesting that studies until June 2008 were included in this review; moreover, that in January 2009 the National Institute for Health and Clinical Excellence (NICE) guidelines advised that 'drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder'.[2]

I am surprised that there were no randomised controlled trials (RCTs) available at the time of study on the usefulness of quetiapine, although some RCTs of aripiprazole and olanzapine were. A few open-label studies have been done highlighting the usefulness of quetiapine in reducing impulsivity and affective symptoms,[3–7] and it is evident in clinical practice that it does have some beneficial effects on mood instability and aggression.

It is a pity that forest plotting could not be done, which would have shown how much variation existed among studies and the degree of precision of each study, although one can understand the various difficulties faced by the authors.

Lastly, I would like to seek clarification regarding somewhat conflicting statements in the paragraph 'Implications for practice and research'; it initially states 'nor can low-dose antipsychotics be advised for cognitive–perceptual symptoms as earlier recommended by the American Psychiatric Association Practice Guidelines', but later states 'the SGAs (aripiprazole, olanzapine) should be the first choice for treating cognitive–perceptual symptoms'.

1 Lieb K, Völlm B, Rücker G, Timmer A, Stoffers JM. Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. *Br J Psychiatry* 2010; **196**: 4–12.

2 National Collaborating Centre for Mental Health. *Borderline Personality Disorder: Treatment and Management*. British Psychological Society & Royal College of Psychiatrists, 2009.

3 Villeneuve E, Lemelin S. Open-label study of atypical neuroleptic, quetiapine for treatment of borderline personality disorder: impulsivity as main target. *J Clin Psychiatry* 2005; **66**: 1298–303.

4 Binks CA, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C. Pharmacological interventions for people with borderline personality disorder. *Cochrane Database Syst Rev* 2006; **1**: CD005653.

5 Van den Eynde F, Senturk V, Naudts K, Vogels C, Bernagie K, Thas O, et al. Efficacy of quetiapine for impulsivity and affective symptoms in borderline personality disorder. *J Clin Psychopharmacol* 2008; **28**: 147–55.

6 Hilger E, Barnas C, Kasper S. Quetiapine in the treatment of borderline personality disorder. *World J Biol Psychiatry* 2003; **4**: 42–4.

7 Adityanjee, Romine A, Brown E, Thuras P, Lee S, Schulz SC. Quetiapine in patients with borderline personality disorder: an open-label trial. *Ann Clin Psychiatry* 2008; **20**: 219–26.

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Authors' reply: We agree that the conclusions from NICE and our review are surprisingly different, considering similar literature search periods and widely similar inclusion criteria for primary studies. However, our scope was to assess and evaluate 'the mere evidence' of clinical outcomes. The National Institute for Health and Clinical Excellence, in contrast, aims at the formulation of instructional recommendations for the British National Health Service. Thus, the steering group may have had a broader view and considered additional criteria such as cost-effectiveness within a complex system of healthcare. Differences may therefore, at least in part, stem from different perspectives and scopes: the assessment of the mere evidence and the formulation of instructional guidelines.

Indeed, there were and still are no RCTs on quetiapine available. We are aware of one RCT (the Verkes Borderline Study) that has not been published (yet). Thank you for the reference list. There are two more open-label trials of quetiapine in borderline personality disorder.[1,2] However, this list is not necessarily exhaustive.

We agree that forest plotting would have contributed to a more immediate understanding of the evidence. However, may we refer you to the full Cochrane review which is to be published soon in the Cochrane Library. Forest plots will be provided there whenever appropriate.

Finally, we thank you for indicating this passage which is indeed liable to misunderstanding. The American Psychiatric Association guidelines recommend low-dose antipsychotics in general,[3] whereas our findings indicate that second-generation antipsychotics are supported by the current RCT evidence in particular. This development of a shift towards second-generation antipsychotics has been foreshadowed by John M. Oldham in his guideline watch of 2005,[4] but, to our knowledge, the original guideline recommendations have not been modified since.

1 Bellino S, Paradiso E, Bogetto F. Efficacy and tolerability of quetiapine in the treatment of borderline personality disorder. A pilot study. *J Clin Psychiatry* 2006; **67**: 1042–6.

2 Roepke S, Merkl A, Dams A, Ziegenhorn A, Anghelescu IG, Heuser I, et al. Preliminary evidence of improvement of depressive symptoms but not impulsivity in cluster B personality disorder patients treated with quetiapine: an open label trial. *Pharmacopsychiatry* 2008; **41**: 176–81.

3 American Psychiatric Association. Practice guideline for the treatment of patients with borderline personality disorder. *Am J Psychiatry* 2001; **158** (suppl 10): 1–52.

4 Oldham JM. *Guideline Watch: Practice Guideline for the Treatment of Patients with Borderline Personality Disorder*. American Psychiatric Association, 2005 (http://www.psychiatryonline.com/pracGuide/pracGuideTopic_13.aspx).

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Sample bias may obscure results

Di Forti *et al*[1] present their paper as further evidence of the link between high-potency cannabis and psychosis. Obviously, a major issue in case–control studies is the sampling, and any difference between case and control groups needs to be carefully considered. The authors state that 'there was no significant difference between the cases and control groups in age, gender, ethnicity, educational qualifications or employment status at time of assessment'. However, I would raise concerns about the employment status

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