ECT at the unit were in keeping with national trends reported by the Department of Health (1999). Over this 3-year period, consultant groups in the unit remained largely unchanged.

Concluding from this study, I feel that ECT is more commonly used in treating older people with depression. Availability of newer antidepressants and other treatment modalities, as highlighted by Eranti & McLoughlin (2003), could be some of the reasons why there is a decline in the number of patients under 65 who receive ECT. Furthermore, the limited response to ECT in the subjects of our study could be due to the fact that these patients had been treatment-resistant. On the other hand, in the case of older people suffering from severe depression, there are other factors that tilt the treatment options towards ECT. Factors such as physical frailty, propensity to develop side-effects from antidepressants, and the serious effects of dehydration and weight loss (as a result of severe depression) make it imperative that depression is controlled rapidly.

I feel that in the future, it will be old age psychiatrists who will be using ECT more commonly as a treatment option for depression. Old age psychiatrists could take a leading role in ensuring that psychiatric trainees have the opportunity to obtain experience in ECT. The effective (albeit reduced) use of ECT resulting in good clinical outcomes will ensure that clinical interest in this treatment modality is maintained.

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Lithium augmentation in treatment-refractory unipolar depression

Stimpson *et al* (2002) have taken an 'all or nothing' approach to evaluating randomised controlled trials (RCTs) for their systematic review. Their rigorous procedures eliminated over 98% of the 919 RCTs considered (although we note that the flow chart in Fig. 1 appears to 'lose' 166 of them without explanation). As a consequence, they have provided a matchless summary of the very best evidence about intervention for treatment-refractory unipolar depression but have left undescribed the very large quantity of remaining levels of evidence.

In 1999 Bauer and Dopfmer identified 11 placebo-controlled studies of lithium augmentation. As always, the trials were of varying quality; nevertheless, they concluded (using the three studies of highest quality, two of which were used by Stimpson *et al*) that there is 'firm evidence' in favour of lithium as an augmentation strategy for treatment-refractory unipolar depression, with a number needed to treat of 3.7. They supported their conclusion by performing a separate analysis adding a further six studies (that used either lower doses or shorter duration of lithium augmentation) and found a similar, indeed slightly stronger, effect size (Bauer & Dopfmer, 1999).

We note that there have been no studies of lithium augmentation against placebo for treatment-resistant unipolar depression that are of a suitable quality for a systematic review in the approximately 3-year period between the acceptance dates of the two papers cited above. We suggest that many clinicians now consider the weight of evidence (at many levels) supporting the use of lithium as an augmentation strategy for treatment-refractory unipolar depression sufficiently compelling. Thus, it is unusual for our service dedicated to treatment-resistant depression to receive referrals of patients not yet tried on lithium. Although further and better RCTs of lithium augmentation would be welcome (even Bauer & Dopfmer identified only 234 subjects studied), many would feel that other questions now have more clinical salience. Pressing examples might include whether psychological treatments are effective in these patients, how they compare with lithium augmentation, and how olanzapine augmentation (for which a large body of evidence is emerging; see Dube *et al*, 2002) compares with both.

Bauer, M. & Dopfmer, S. (1999) Lithium augmentation in treatment-resistant depression: meta-analysis of placebo-controlled studies. *Journal of Clinical Psychopharmacology*, **19**, 427–434.

Dube, S., Anderson, S. W., Paul, S., *et al* (2002) Metaanalysis of olanzapine–fluoxetine use in treatment resistant depression. *International Journal of Neuropsychopharmacology*, **5** (suppl. 1), 105–106.

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Authors' reply: According to Drs Lee and Cleare 'many clinicians' regard the current evidence for lithium augmentation in treatment-refractory depression as 'compelling'. They are correct in repeating one of the principles of evidence-based medicine, that all levels of evidence need to be taken into account when making clinical decisions.

Previous systematic reviews of this area have included patients who have had $\leqslant 3$ weeks' treatment with an antidepressant or who have bipolar disorder. We do not think that many UK psychiatrists would consider lithium augmentation in unipolar depression that had not responded to an antidepressant for only 3 weeks. For patients with bipolar disorder, most UK psychiatrists, we think, would in any case be treating with lithium or another mood-stabiliser. Our inclusion criteria, which were set before the review started, were based therefore upon sensible and pragmatic clinical considerations.

We too were surprised and shocked by the lack of randomised evidence to support lithium augmentation; but it is also important to remember that lithium may well be effective, even though the evidence to support its use is extremely weak.

Lithium has a number of potentially serious side-effects, even at normal therapeutic doses (Bell *et al*, 1993). When we discuss the advantages and disadvantages of lithium with our patients we are unable to provide them with much more than clinical anecdote in its favour. We certainly have no idea from empirical research about the severity of depression for which lithium augmentation might be effective.

We have a collective responsibility to our patients to provide them with good-quality research evidence to justify the treatments we recommend. As a profession we need to address areas of uncertainty

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