Correspondence

Trainees in the specialities

Sir: Approaching the end of my senior registrar training in Old Age Psychiatry I found John Sandford's letter (*Psychiatric Bulletin*, February 1997, **21**, 120) particularly apposite.

I have obtained utterly conflicting advice from senior members of the College regarding the value of dual accreditation in Old Age and General Psychiatry. I am thus in the position of having an acceptable training in Old Age Psychiatry, but the Section of OAP has now moved the goalposts and recommended that senior/specialist registrars obtain dual accreditation and consequently extend their training. It is very frustrating to see senior trainees in General Psychiatry taking up consultant posts after only three years in the grade while those of us in the specialities ponder the risks of being singly accredited consultants. Surely we are all psychiatrists and so why cannot we all aim for a CCST in psychiatry and then allow our curriculum vitae to indicate any special interests? Currently chaos reigns and consultant recruitment in the specialities is suffering. The Section of OAP is now recommending that Trusts look to the US for consultant staff. Are Americans better trained than home-grown psychiatrists? The situation would be laughable were it not so tragic for the future of British psychiatry.

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Sir: I can understand Dr Thacker's confusion. I am afraid it has been a confusing situation for all of us. The issue was discussed again at the Joint Committee for Higher Psychiatric Training (JCHPT) on 26 March and my understanding of the current situation is that a Certificate of Completion of Specialist Training (CCST) is necessary to practise as a consultant, but that obtaining a CCST in General Psychiatry does not imply the inability to practise in Old Age Psychiatry or vice versa. Presumably the College representative on the Appointments Committee would take into account details of the curriculum vitae as well as in what area a CCST had been granted. My understanding is that CCSTs are permissive rather than restrictive. However, I can understand anybody currently in training deciding to go for a dual CCST because none of us can be certain how the situation will evolve in the future. A number of established consultants in Old Age Psychiatry have argued successfully that they should be on the Specialist Register as both General and Old Age Psychiatrists, which reflects concern over similar issues but does not imply, as in Dr Thacker's case, the need for an extra year in training. I am not happy with the Old Age Section being cast as the villain. Like JCHPT and other College bodies, we are doing our best to interpret an evolving situation which we do not control. Finally, I should stress that the Old Age Section is not particularly recommending that Trusts look to the US for consultant staff. This recommendation was one of the Department of Health's solutions to the current manpower crisis and was merely reported through the Old Age Section. As a matter of policy the Old Age Section would prefer training of Specialist Registrars within the UK to meet our own needs for consultant appointments.

J. P. WATTIS, *Chairman of the Section for Psychiatry and Old Age*

Disulfiram implantation

Sir: Shergill *et al* (*Psychiatric Bulletin*, October 1996, **20**, 624) report beneficial outcome in six of twelve patients treated with disulfiram implantation and mention our similar findings (Malcolm & Madden, 1973). They do not, regrettably, mention our second paper (Malcolm *et al*, 1974) which confirmed our initial impression that implants were pharmacologically inactive. Our implants produced minimal and short-lasting levels of blood disulfiram and of metabolite in exhaled breath, as compared with oral use. The implant dose, which is alleged to last for six months, is miniscule in comparison with the total oral dosage over the same period. We saw no true reactions to alcohol in our implanted patients. Shergill and colleagues did not attempt a 'challenge' with alcohol. We note that a third of their patients drank, seemingly with no reaction. Most of their patients requested the implant, a situation we encountered, which shows patients' high expectations, even suggestibility – patients know what a reaction should be and their subsequent experiences are psychogenic or the misinterpreted effects of alcohol.

It is reported (van der Lann, 1992) that 50 000 alcoholics at one Russian clinic have received the traditional 'Esperal' implants or the intravenous 'torpedo' of disulfiram; although no deaths have resulted, many are convinced that they will die if

they drink! Heather (1993) has written, "implantation was pioneered by Wilson (1995) in Canada". In fact the initial study was that of Marie in 1955; his work and a variety of French and Italian papers in the 1950s and 1960s are discussed in Jacques' booklet (1970). Marie in 1955 also doubted the activity of implants.

We agree with Shergill and co-workers that, "implantation has a powerful placebo effect", in our view solely placebo, certainly after the first week. It would be interesting to see our biochemical investigations repeated. We still believe, as in 1974, that for disulfiram, "the need exists for development of an alternative form of parenteral administration".

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JACQUES, D. (1970) *Etude de l'utilisation de l'implant de disulfirame dans le traitment de la maladie alcoolique*. Monographie No 2, Du Centre International, D'Alcoologie/Toxicomanies: Lausanne (Suisse).

MALCOLM, M. T. & MADDEN, J. S. (1973) The use of disulfiram implantation in alcoholism. *British Journal of Psychiatry*, **123**, 41–45.

—, — & WILLIAMS, S. E. (1974) Disulfiram implantation critically evaluated. *British Journal of Psychiatry*, **125**, 485–489.

VAN DER LANN (1992) *Financial Times*, 14 Nov.

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SSRI prescribing in the elderly: caution required

Sir: McAskill & Taylor (*Psychiatric Bulletin*, January 1997, **21**, 33–35) rightly bring to our attention the potential dangers associated with prescribing antidepressants, particularly SSRIs in the elderly. The syndrome of inappropriate antidiuretic hormone secretion (SIADH) is not uncommon in the elderly (Bouman *et al*, 1997*a*) and may lead to serious neurological sequelae. We agree that more careful monitoring of sodium levels are required in these cases, although in our experience this is not yet current practice. As is pointed out in their account, most information on the subject is through individual case reports at present, although we have made a retrospective study of elderly psychiatric in-patients prescribed SSRIs to assess the incidence of SIADH. Preliminary results suggest an incidence of 10% of SSRI-induced hyponatraemia associated with SIADH. These results need further validation and suggest the need for a larger prospective study to be carried out.

We would also like to draw the authors' attention to a report in press which describes the cross-over effect between one class of antidepressant and another (Bouman *et al*, 1997*b*). In this case hyponatraemia due to SIADH occurred both when sertraline and when lofepramine were prescribed at different times. This would suggest that this phenomenon is not a class effect as previously suggested (Ball & Hertzberg, 1994).

BALL, C. J. & HERZBERG, J. L. (1994) Hyponatraemia and selective serotonin inhibitors. *International Journal of Geriatric Psychiatry*, **9**, 819–822.

BOUMAN, W. P., JOHNSON, H. & PINNER, G. (1997*a*) Inappropriate antidiuretic hormone secretion and SSRIs. *British Journal of Psychiatry*, **170**, 88–89.

—, —, TRESCOLI-SERRANO, C., *et al* (1997*b*) Recurrent hyponatraemia associated with sertraline and lofepramine. *American Journal of Psychiatry*, in press.

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Sir: I would like to comment further on the recent drug information quarterly (*Psychiatric Bulletin*, January 1997, **21**, 33–35). A review of spontaneous reports of hyponatraemia and the syndrome of inappropriate anti-diuretic hormone (SIADH) associated with the use of selective serotonin reuptake inhibitors (SSRIs) concluded that the elderly may be at increased risk (Liu *et al*, 1996). Diuretics are commonly prescribed to the elderly in primary care, and often their usage is inappropriate, for example, to treat gravitational oedema (*British National Formulary* 31, March 1996, Prescribing in the Elderly). Hyponatraemia is a well recognised adverse effect of thiazide diuretics in the elderly, especially among elderly women (Baglin *et al*, 1995). Concurrent prescription of SSRIs and a diuretic may therefore increase the risk of hyponatraemia and will create difficulties in identifying the culprit drug, as both will cause an increase in urine osmolality. I suggest caution is exercised in the concurrent prescription of SSRIs and diuretics in the elderly, and that if this combination is used, it is accompanied by regular measurements of serum sodium.

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