the columns

correspondence

Sodium valproate or valproate semisodium?

I read with interest the article by Fisher & Broderick regarding the differences between sodium valproate and valproate semisodium in the management of bipolar disorder (*Psychiatric Bulletin*, December 2003, **27**, 446–448). I would like to comment on both the accuracy of the information presented and highlight important information not included in the article.

The vast majority of trials use valproate semisodium, with over 4000 bipolar patients involved in these studies. The authors erroneously state that the Pope *et al* (1991) study used sodium valproate, when in fact valproate semisodium was used in this placebo controlled trial.

The search criteria used did not include data published in 2003 and consequently missed a further large, randomised, controlled trial which compared valproate semisodium with olanzapine in the management of bipolar disorder, and showed no difference in rates of bipolar relapse between both agents (Tohen *et al*, 2003).

With regard to tolerability, it should be noted by the authors that the most commonly used preparation of sodium valproate in the UK, Epilim Chrono, is not enteric coated and will therefore break down to valproic acid in the stomach and small intestine. The studies showing improved tolerability of valproate semisodium *v.* valproic acid therefore have some particular relevance to the UK.

Finally, the National Institute for Clinical Excellence (2003) has recently reviewed extensively the evidence regarding the use of valproate semisodium in the management of bipolar disorder, and the guidelines specifically state that this compound is recommended for the treatment of acute mania associated with bipolar I disorder.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2003) Olanzapine and valproate semisodium in the treatment of acute mania associated with bipolar disorder I disorder. Technology Appraisal 66. www.nice.org.

POPE, H., McELROY, S. L., KECK, P., *et al* (1991) Valproate in the treatment of acute mania. A placebo-controlled study. *Archives of General Psychiatry*, **46**, 62–68.

TOHEN, M., KETTER, T., ZARATE, C., *et al* (2003) Olanzapine versus divalproex sodium for the treatment of acute mania and maintenance of remission: a 47 week study. *American Journal of Psychiatry*, **160**, 1263–1271.

Paul Mackin Academic Specialist Registrar in Psychiatry, School of Neurology, Neurobiology and Psychiatry, Psychiatry, Leazes Wing, The Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne NE1 4LP

Authors' response

We would wish to thank Dr Mackin for pointing out our error in stating that the Pope *et al* (1991) study used valproate semisodium and not sodium valproate. He also draws attention to a possible misinterpretation in our section on tolerability. We did not wish to imply that Epilim Chrono, a combination formulation of sodium valproate and valproic acid, was enteric coated. However we believe this does not alter our underlying opinion that US data derived from non-enteric coated forms of valproate should not be extrapolated in relation to the general use of valproate in the UK, unless interpreted cautiously. Epilim Chrono by nature of its modified release formulation does not release a bolus of valproate in the stomach and based on the assumption that gastric side effects are concentration related, cannot be regarded as the same as non-enteric coated valproate with respect to gastric side effects. Although Epilim Chrono may be the most commonly used preparation in the UK, figures from the Prescription Pricing Bureau in England show that it only accounts for around 30% of valproate items dispensed in tablet form.

At the time we submitted our paper, 2003 data mentioned by Dr Mackin were not available to us. Dr Mackin mentions the NICE (2003) Technology Appraisal, number 66. We were surprised by the government-directed remit for this particular appraisal, set out in section 3.1; that only medicines with a licence for the treatment of bipolar disorder were to be considered. This is in contrast to other areas of medicine where NICE have clearly felt 'off licence' use was within their remit. One effect of this was to exclude drugs with an established 'off licence' use and create a spurious belief among many psychiatrists that valproate semisodium had to be used in preference to other forms of valproate because it was the only form approved of by NICE. Local Drug and Therapeutics Committees were left to struggle with this issue.

Chris Fisher Medical Director, **Wendy Broderick** Trust Chief Pharmacist, Central Resources, Earls House, Lanchester Road, Durham DH1 5RD

Risperidone long-acting injection

We were pleased to read of the positive experience with long-acting risperidone by Paton & Okocha (*Psychiatric Bulletin*, January 2004, **28**, 12–14). The abstract, however, appeared inconsistent with the data describing generally positive patient outcomes. From the abstract alone, the findings with long-acting risperidone sound more negative than they actually were.

Specifically, the authors studied a difficult-to-treat population (42 of 50 patients with histories of non-compliance or unacceptable extrapyramidal side-effects). Even in this population, a majority (54%) had at least minimal improvement, with 40% (20 of 50 patients) being seen as 'much or very much improved'. This is impressive considering the population examined, but the authors do not mention this context when drawing their conclusions.

Further, one might view a 40% attrition rate to be a positive outcome given that patients were selected largely on the basis of noncompliance. Comparison with a published one-year trial (Fleischhacker *et al*, 2003) may not be entirely appropriate as patients in the latter were selected on the basis of clinical stability, not noncompliance, and most were switched from oral atypical, not depot, antipsychotics.

We agree with Paton & Okocha about the need for additional information regarding long-acting risperidone, including mention that at least 6 months of therapy are needed before assessing outcome. However, we interpret their findings as supportive of the potential for

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further improvements among more severely ill or difficult to treat patients, complementing the 'average' patients studied by Fleischhacker *et al*. Hopefully, readers will consider the full report before reaching conclusions about the potential impact of long-acting risperidone for their particular patients.

FLEISCHHACKER, W. W., EERDEKENS, M., KARCHER, K., *et al* (2003) Treatment of schizophrenia with long-acting injectable risperidone: a 12-month open-label trial of the first long-acting second-generation antipsychotic. *Journal of Clinical Psychiatry*, **64**, 10, 1250–1257.

John M. Kane The Zucker Hillside Hospital, Glen Oaks, NY, ***Robert Lasser** Janssen Medical Affairs, LLC, Titusville, NJ 08560-0200. E-mail: rlasser@janus.jnj.com, **Edward Crumbley** Janssen Medical Affairs, LLC, Titusville, NJ

Perverse incentives

Whether or not the incentive to be able to retire early from what your survey confirms to be an overworked and undervalued profession is 'perverse' (*Psychiatric Bulletin*, April 2004, **28**, 130–132) is a matter for debate. Nevertheless, many psychiatrists will undoubtedly have taken it into account when choosing their career. More to the point, many mental health officers (MHOs) will have made important financial planning decisions based upon a 'guarantee by law' (A guide to the National Health Service (NHS) pensions scheme, National Health Service Pensions Agency, 2001) that such an entitlement will remain in place. Given that there may be moves by the government to change the law and hence remove such a guarantee, do the authors not consider it unwise to describe what many consider to be one of the few 'perks' of psychiatry in such a way?

Given the substantial financial incentives of non-NHS work, have the authors not considered the potentially disastrous consequences for an already strained profession that the removal of MHO status might lead to?

Mike Cooper Consultant in General Adult Psychiatry, Rotherham District General Hospital

Retirement

Pleased initially simply to have avoided the cut on being an 'older' psychiatrist (Mears *et al*, *Psychiatric Bulletin*, 2004, **28**, 130–132), I reflect that past 45, I enjoy my job, have a great team of colleagues and rarely complain about my income – only my outgoings. Having left two consultant posts behind me (happily filled), I hope to train somebody to jump aboard when I shuffle off at 55 or 56. This may be too early to retire from life, but as the old joke observes, nobody lies on his deathbed mourning that they hadn't spent more time in the office. Unless the world is turned upside down, there will be no shortage of part-time, locum, medico-legal and private work to do should I wish to continue as a psychiatrist. If I'm spared, I might prefer a life change.

The average age of the sample was 56, so it is unsurprising that those still registered and compos mentis were still working. I wonder how many of the sample with mental health officer status planned to work beyond the point at which they achieve maximum pension? Nobody I know has stayed more than a year or two. If appearances are anything to go by, most of them look 10 years younger within months of retirement. I will be surprised if your columns are full of post-retirement psychiatrists bemoaning their premature trips to the sun: they'll all be too busy to write.

Andrew McBride Consultant Psychiatrist, Specialist Community Addictions Service, The Rectory Centre, Rectory Road, Oxford OX4 1BU, e-mail: andrew.mcbride@oxmhc-tr.nhs.uk

Sociological support for importance of complementary and alternative medicine (CAM)

The timely article by Bhugra *et al* (*Psychiatric Bulletin*, February 2004, **28**, 36–39) may not be welcomed by all readers. Therefore, I would like to support their view that psychiatrists – and indeed other physicians – should take an interest in whatever their patients resort to for relief of symptoms. For additional reading, I recommend a chapter by Goldstein (1999). Already more than 10 years ago, it was estimated that Americans made considerably more visits to unconventional providers than to all primary care physicians. By so doing, they spent $13.7 billion more than they spent out of pocket on conventional care that same year. Some insurance companies and health maintenance organisations offer coverage for some forms of alternative care. Listings in the *Healthy Yellow Pages* for Los Angeles are hilarious and informative alike.

In the 16th century, few liked to believe that the earth is not the centre of the universe. Now, most medically trained people prefer to perceive themselves as central to providing health care. The perspective seems to be different for many on the receiving end.

GOLDSTEIN, M. S. (1999) The growing acceptance of complementary and alternative medicine. In *Handbook of Medical Sociology* (ed C. E. Bird, P. Conrad & A. M. Fremont), pp. 284–297. Harlow: Pearson Education Limited.

Cornelia Thiels Professor of Social Medicine, Department of Social Sciences, University of Applied Sciences, Bielefeld, Germany

Liaison psychiatry

I would like to echo the view of liaison psychiatry expressed by Dr Bolton (*Psychiatric Bulletin*, April 2004, **28**, 149). When I moved to Wolverhampton nearly 6 years ago, there was a very well thought of nurse-led liaison psychiatry service which as well as providing an excellent response to the local accident and emergency department also was developing links with particular specialties. The service had been based at the general hospital along with the psychiatric beds, but when the latter were relocated to a purpose-built facility on a different site in December 2002, the liaison service lost its accommodation on site. Foreseeing this, we had provided a detailed service specification well in advance of the move; we were later told this had been 'lost', so resupplied it. At around the same time, there was a change in management as we were absorbed into the primary care trust and senior management became very interested at the point where it became clear that there had never been a service level agreement with the acute trust. The service was entirely funded from mental health, apart from one seven session psychology post that continues to be funded by the acute trust.

A number of meetings have taken place between senior management and clinicians between the primary care trust and the acute trust but these have proved frustratingly inconclusive. Despite the fact that my one or two sessions of input to the service remain significantly below the recommended norm of about two full-time equivalents for the size of the hospital, the team has continued to provide a well-thought of service which is valued by clinicians in the acute trust. Goodwill has not translated into funding however, and because the primary care trust has entered the new financial year short of cash, it is proposing to cut two nursing posts and redeploy the third into another needy area of mental health. The thinking behind this is presumably along the lines; 'If it ain't broke . . . let's tinker with it until it is, and then we can abolish it . . . .'

Teresa Black Consultant Psychotherapist, Clevelands House, 10/12 Tettenhall Road, Wolverhampton, WV1 4SA

The objective structured clinical examination (OSCE)

The objective structured clinical examination was introduced in spring 2003 as a more comprehensive and a fairer method of assessment of the clinical abilities of the candidates for the Part I MRCPsych. It was thought that this method would examine candidates' clinical abilities over more clinical subjects than the traditional long case could achieve. Instead of having

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