Letters

NEW DRUGS: THE WHOLE STORY

Dr John Battaglia's article about intramuscular (IM) olanzapine (Out of the Pipeline, CURRENT PSYCHIATRY, May 2004, p. 76-88) appears biased because of his pharmaceutical company connection. He mentions four studies supporting its use in treating schizophrenia, bipolar type I mania, and dementia.

As a resident eager to learn what constitutes good clinical care, I feel the article does an injustice by mentioning no negative studies or those that recorded no significant change.

Getting all the facts is key to establishing how to best use a treatment. Debate or unbiased commentary should accompany articles on new medications/treatments.

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Dr. Battaglia responds

I appreciate the passion with which Dr. Sager is approaching his education; he might want to learn more about drug development.

For decades, the overwhelming majority of FDA approvals for psychiatric medications have resulted from industry-supported studies. Very few researchers are doing substantial psychopharmacology clinical trials without industry support. It is extremely difficult to publish "negative" studies or those that show "no significant change." I am not aware of any such published studies with IM olanzapine.

The best "unbiased" commentary on IM olanzapine will occur when it is used widely in clinical practice. For now, we are limited to published studies.

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TREATING TARDIVE DYSKINESIA

"Tardive Dyskinesia: How to prevent and treat a lingering nemesis" (CURRENT PSYCHIATRY, October 2003, p. 59-66) was a very good, basic article. The algorithm on managing tardive dyskinesia was particularly helpful, and the information on possible reversible dyskinesias with mood stabilizers and with antihistamines such as Benadryl was a useful refresher.

For MDs such as I who practice in rural clinics, however, more-specific dosage information would be useful—even for experimental agents such as tetrabenazine—since we do not have ready access to higher-level movement disorder clinics. The nearest such clinic to my practice is 2 1/2 hours away, an impossible commute for many of my patients.

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TREATING DEPRESSION, CHRONIC PAIN

We read with interest Dr. Nelson's and Dr. Krahn's article on treating chronic pain and comorbid major depression (CURRENT PSYCHIATRY, May 2004, p. 51-68).

We treat many patients who present with depression and chronic pain—often as a partial cause of their depression. The article's recommendations will be most useful.

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We have found that two agents—lamotrigine and mirtazapine—have been particularly helpful. The authors, however, did not mention these agents or only briefly referred to them.

Lamotrigine, although not FDA-approved for these uses, has demonstrated efficacy in unipolar depression[1] and chronic pain.[2] Although the medication has not been studied for treating comorbid depression and chronic pain, we can attest to its usefulness for such patients.

Mirtazapine is FDA-approved for depression and has been compared favorably with selective serotonin reuptake inhibitors[3-4] or venlafaxine.[5] Fewer data support using mirtazapine for chronic pain, but its sedating effects make it an option for treating any syndrome associated with sleep disturbance—ie, major depression and chronic pain.

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