2918

## Imprisonment of J-P Allain

SIR—The undersigned (directors of UK blood transfusion centres, colleagues of Professor Allain in Cambridge and elsewhere in East Anglia, and others) wish to record our dismay at the sentencing by the French courts of Jean-Pierre Allain, professor of transfusion medicine in Cambridge, to a term of imprisonment. His alleged crime is to have done too little, when he was working in Paris in 1984–85, to prevent the transmission of HIV to haemophiliacs. The decisions made there were similar to those made all over the world by countries with developed transfusion services and reflect the uncertainties of that time rather than the certainties of today. To call the decisions criminal, when they were due essentially to lack of knowledge, seems to us to be bizarre and merely indicates that the haemophiliac community in France needs to find someone to blame for the tragedy of AIDS acquired by transfusion. It is ironic that Professor Allain should be chosen as a victim since the effective treatment of haemophilia has been one of his chief interests. Furthermore, he has been recognised by *Science* (1993; **260:** 1262) as one of the outstanding contributors to AIDS research over the past five years. Finally, his role in the events in Paris in 1984–85 has been vindicated by two independent reviews by his peers in this country. We share the concern of our colleagues in France at the sentencing of Professor Allain and will work with them in attempts to right this injustice. In the meantime, we look forward to his return to transfusion science and medicine in this country.

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## Antidepressants and old people

SIR—Tallis (June 5, p 1444) questions the advisability of continuation/prophylactic treatment with antidepressants in the elderly,[1] and is concerned that depression may be overdiagnosed and overtreated, thereby putting patients at risk of adverse effects while offering little benefit. He suggests that, because of difficulties in diagnosing depression and the possible reactive nature of the depression, too many elderly people may be treated with antidepressants.

In a comparison of placebo with antidepressant in the elderly physically ill, 28% of inpatients had depression. Among the first 50 patients entered into our trial, 50% dated the onset of their symptoms at least six months before presenting with physical problems; only 2 of these had received any treatment. The underdiagnosis of depression in the elderly has been demonstrated time and again; where it is diagnosed, treatment is not usually given.[2]

Chronic use of unnecessary medication should of course be avoided. But depression is also an illness, and if untreated is associated with increased mortality and morbidity. Even in the severely physically ill elderly patient, depressive symptoms improve substantially on fluoxetine, without adverse effects.[3] This twelve month prospective study showed a lower mortality of the treated group than in the psychologically well. Depression in the elderly is indeed life-threatening,[4] and the suicide rate is more than twice that of other age groups; three-quarters of elderly suicides have been seen by their primary care physicians within a month of their deaths.[2]

Tallis states that only 69 of the 219 patients in the Old Age Depression Interest Group (OADIG) sample[1] could be randomised because a large number of patients failed to respond to dothiepin in the acute episode; this was not so. Patients in the original sample were treated in whatever way the participating investigators wished and no restriction was made about particular drugs or electroconvulsive therapy. These patients were severely depressed. The failure to recover sufficiently or the "fragility of recovery" which excluded many patients from the randomised trial is not unusual, and the fact that clinicians were reluctant to jeopardise their patients' recovery from a devastating depressive illness underscores their commitment to the value of therapy.

We know that good prognosis is associated with aggressive and sustained treatment.[5] Long-term maintenance therapy and community support offer the best combination of therapy. Failure to treat depressed elderly patients is a missed opportunity to increase greatly the quality and length of life of our elderly patients.

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1 Old Age Depression Interest Group. How long should the elderly take antidepressants? A double-blind placebo-controlled study of continuation/prophylaxis therapy with dothiepin. *Br J Psychiatry* 1993; **163:** 175–82.
2 Alexopoulous GS. Editorial: Geriatric depression reaches maturity. *Int J Ger Psychiatry* 1992; **7:** 305–62.
3 Evans ME. Depression in elderly physically ill inpatients: a twelve-month prospective study. *Int J Ger Psychiatry* (in press).
4 Murphy E, Smith R, Lindesay J, Slattery J. Increased mortality rates in late-life depression. *Br J Psychiatry* 1988; **152:** 347–53.
5 Baldwin RC, Jolley D. Prognosis of depression in old age. *Br J Psychiatry* 1986; **149:** 574–83.

### *Author's reply*

SIR—I can understand why Jacoby (July 10, p 113) was dismayed by my critical commentary on his joint paper but this does not excuse his charging me with "ageism" or his misrepresentation of my views. I did not say that "old people lead such horrid lives they have 'a right to be depressed' ". His words, not mine.

It is usually easy to recognise that a patient is depressed. But it is sometimes less easy to decide, in the context of serious physical illness and/or adverse social circumstances, whether the depressed affect will benefit from antidepressant drugs. Jacoby is wrong to suggest otherwise and to deny that the diagnosis of depression (that, for example, someone's grieving is "pathological") is a matter of clinical judgment. I did not say that the diagnosis of depression is "invalid", only that it cannot be as objective as the diagnosis of myocardial infarction. Not all affective disorders in old age present as in the example Jacoby gives, where the case for drug treatment is overwhelming.

My article referred to the dangers of underdiagnosing and of overdiagnosing mental distress that will respond to antidepressant drugs. I emphasised overdiagnosis because, other than in the OADIG trial, antidepressants, especially when given as chronically as Jacoby recommends, have had serious adverse effects. A decade of research into adverse drug reactions and inappropriate pre-scribing has convinced me that the latter is the commonest cause of the former.[1] Drugs are fired at elderly people like buckshot in the dark. Moreover, their effects are not monitored by prescribers.[2] In the real world, a blanket recommendation of 2 years' antidepressant treatment is therefore dangerous, especially when it has a poor scientific basis.

With respect to Hammond and colleagues, whereas it may well be that "good prognosis is associated with aggressive and sustained treatment", the OADIG trial provides insufficient proof. The OADIG study was worthwhile because, as I wrote, "Prevention of relapse in such a distressing (and sometimes life-threatening) condition is clearly desirable". That is why the study needs to be done again and better. It is not ageist to want to protect patients against injudicious prescribing.

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