

study method then talks about antidepressant use in general—but their findings once more specify TCA use only. One wonders whether the psychiatrists were asked about TCA use or about the use of antidepressants in general; if the former was the case then it might explain the relatively rare reports of use of drugs other than the TCAs, even in adolescents.

Also, although I realise there must be a long “lead time” before publication, it seems strange for an article to quote from a *British National Formulary* which has been out of date for more than a year—and to state, in July 1992, that fluvoxamine and fluoxetine are “the latest 5-HT re-uptake inhibitors”!

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Reply

DEAR SIRs

We are concerned that the terminology concerning antidepressants employed in our paper led to some perplexity on Dr Leigh's part. In our prescription survey we sharply differentiated between the tricyclic (or related) antidepressants and other agents which may also be used in given conditions which are indications for the tricyclics (lithium, carbamazepine, MAOIs, etc). Upon reflection it may have been more correct to use the term “monoamine re-uptake inhibitor” (MARI) in preference to “tricyclic antidepressant”; however, we believe that the latter term is still a widely used generic term for this admittedly increasingly heterogeneous group of drugs. Whether they are “antidepressants” or “antidepressives” is quite another matter! None of the 248 respondents to the survey indicated similar problems with our terminology, therefore, for the purpose of interpreting our results the term antidepressant is synonymous with term tricyclic “or related” agent unless stated otherwise.

Regarding our description of fluoxetine and fluvoxamine as “the latest 5-HT re-uptake inhibitors”, we acknowledge that they may well be rather old news to most clinicians yet in the gentle, careful groves of British child psychiatry they are indeed new and possibly rather threatening commodities. Remember, we discovered that those old work horses amitriptyline and imipramine are still far and away the most popular “tricyclic” antidepressants prescribed by the specialty.

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St Charles Centre

DEAR SIRs

We are writing to correct some errors of fact in the letter from T.D. Scannell (*Psychiatric Bulletin*, 1992, 16, 509). This letter makes a number of comments about St Charles Youth Treatment Centre, now St Charles Centre, part of the Youth Treatment Service (YTS), which merit a reply.

The letter suggests that management are intending to employ more psychologists. This is not the case: the complement for psychologists at St Charles numbers two (as it does at the Glenthorne Centre in Birmingham, also part of the YTS). With regard to the role of psychiatrists, there are arrangements in hand for formalising service contracts that will benefit both Centres by having psychiatrists who will participate in the work of multidisciplinary teams. The role of psychiatrists, like their professional colleagues, will be to contribute to clinical work, research, and training within the YTS. This is a long way from the monitoring of medication noted in your correspondent's letter, and will ensure the highest quality of service for the young people entrusted to the care of the YTS.

With regard to clinical autonomy, it is recognised within the YTS that clinicians have their professional codes of conduct and must act in the best interest of their client. It is not the policy of the YTS to seek to compromise clinical responsibility in any way.

There has not been a political directive that has changed the ethos at the St Charles Centre. Further, despite your correspondent's comments, the ethos at St Charles is not behavioural. (In any case, we would wish to resist the stereotype that behavioural practice has an emphasis on care and control: good behavioural practice is both psychotherapeutic and growth-enabling.)

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Doctors in management

DEAR SIRs

There is no doubt that management education should form part of the training of every clinician, as stated by Gadd & England (*Psychiatric Bulletin*, August 1992, 16, 484–485).

Doctors have been encouraged to be directly involved with the NHS management process (Griffiths Report, 1983). This report generated the clinical directorate concept for unit management. Exposure to management development aims at

personal management (managing, planning and control); staff management (recruitment, leadership and motivation); managing in organisation (organisational structure, culture conflict, managing change) and management and the external world. Developing the role of doctors in the management of the NHS was highlighted by the NHS Training Authority in its discussion document (1986). So management training became an ongoing process, with a number of possible options: in-service training, shadowing a manager, local mentor, managerial tailored senior registrar posts and secondment to regionally designed courses like those on offer by the North West Regional Health Authority, including the management education syllabus and open learning courses with the Open University. Therefore management syllabuses do exist. The Royal College of Psychiatrists' working party on management training (1990) stated that management training should be recognised and endorsed as an intrinsic part of psychiatric training; a management training co-ordinator should be appointed in all training schemes; and that the JCHPT might consider making it a mandatory requirement for approval of higher psychiatric training. So, the structure in which training and development may be delivered also exists.

A separate "core curriculum" for management training of doctors, apart from other NHS professionals, might not be the right prescription in the new NHS, where partnerships based on collaborative working and a shared sense of ownership among all interested parties are keys to success.

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References

- GRIFFITHS, R. (1983) *Management Enquiry* (Griffiths Report). London: DHSS.
- NHS TRAINING AUTHORITY (1986) *Developing the Role of Doctors in the Management of the National Health Service: a discussion document*.
- ROYAL COLLEGE OF PSYCHIATRISTS (1990) The CTC Working Party Report on Management Training. *Psychiatric Bulletin*, **14**, 373–377.

Thyrotoxicosis during lithium therapy

DEAR SIRs

I read with interest the report (*Psychiatric Bulletin*, July 1992, **16**, 445–446) about thyrotoxicosis during lithium therapy in a mentally handicapped patient but do not feel it supports 'the possibility of thyrotoxicosis as a rare complication'. While the author is correct to point out that the relationship between lithium therapy and concomitant thyrotoxicosis is unclear, the case only adds to the confusion as it

contained no new data. The following points may be noteworthy.

(a) As there is no mention of pre-lithium measurement of thyroid antibody titre, thyroid ultrasonography, or even clinical assessment of thyroid status (e.g. a small firm goitre which may indicate Hashimoto's thyroiditis), it is possible that the patient suffered from (subclinical) autoimmune thyroid disease prior to lithium therapy. There is growing evidence for the immunomodulatory effect of lithium on thyroid antibody activity, exacerbation of pre-existing autoimmune thyroid disease and hence thyroid dysfunction (Wilson *et al*, 1991). Higher age group, as in this case, is a recognised risk factor for thyroid autoimmunity.

(b) The subsequent need for radioiodine for anti-thyroid treatment suggests that the patient suffered from Graves' disease (rather than Hashimoto's thyroiditis which commonly presents as hypothyroidism). Although not mentioned by the author, Graves' disease is usually associated with a diffusely enlarged, vascular, and soft-to-firm goitre. If this is the case, the thyrotoxicosis is most unlikely to be caused by lithium which has been used successfully in the treatment of Graves' disease (Lazarus *et al*, 1974). The stopping of lithium in the patients, albeit temporary, was therefore unnecessary.

(c) Data on lithium-associated thyroid disorders are overwhelmingly based on Caucasian patients living in Western countries. Recently, we studied the thyroid function of 50 Chinese psychiatric patients on chronic lithium treatment. Apart from a high rate of goitres (50%), five patients (10%) had single or multiple episodes of hyperthyroidism, whereas only two patients exhibited biochemical hypothyroidism. We argued that variation in iodine status, dietary goitrogens, immunogenetic makeup and their complex interactions with chronic lithium treatment may contribute to ethnically different patterns of thyroid abnormalities (Lee *et al*, in press). Thyrotoxicosis during lithium therapy may not be as 'unexpected' in a non-Western culture.

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References

- LAZARUS, J. H., RICHARDS, A. R., ADDISON, G. M. & OWEN, G. M. (1974) Treatment of thyrotoxicosis with lithium carbonate. *Lancet*, *ii*, 1160.
- LEE, S., CHOW, C. C., WING, Y. K. & SKEK, C. C. (in press) Thyroid abnormalities during chronic lithium treatment in Hong Kong Chinese—A controlled study. *Journal of Affective Disorders*.
- WILSON, R., MCKILLOP, J. H., CROCKET, G. T. *et al* (1991) The effect of lithium therapy on parameters thought to be involved in the development of autoimmune thyroid disease. *Clinical Endocrinology*, **34**, 357–361.