Psychiatric Bulletin (1991), **15**, 222–229

Correspondence

L-tryptophan and EMS

DEAR SIRS

We are grateful to Dr Cowen for providing his expert opinion on L-tryptophan and the eosinophilia-myalgia syndrome (*Psychiatric Bulletin*, December 1990, **14**, 738–739). We agree with his contention that L-tryptophan is not an essential first-line treatment in the management of depression.

The recent guidelines of the European Community Committee on Proprietary Medicinal Products for the investigation of antidepressant drugs propose that efficacy is established not only in the treatment of acute episodes of illness, but also in maintenance treatment following resolution of the acute episode, and in prophylaxis to reduce the risk of new episodes. The evidence for efficacy of L-tryptophan in short-term treatment is somewhat limited – a thorough review (d'Elia *et al*, 1978) suggests that L-tryptophan is probably inferior to 'standard' antidepressants such as imipramine, and is not significantly different to placebo. Furthermore, there is no convincing evidence for the efficacy of L-tryptophan in long-term treatment, and it is therefore difficult to recommend such treatment when evidence of long-term benefit is scarce.

Although L-tryptophan may occasionally be found to be useful in combination treatment of chronically-ill or treatment resistant depressed patients, caution must be exercised when interpreting reported results. It is regrettable that there are no generally accepted criteria for 'resistant' depression. Perhaps the most acceptable definition of 'chronicity' is that of Cassano *et al* (1983), i.e. symptomatic non-recovery for a period of two or more years. However, utilisation of even this simple definition results in the description of a diverse and heterogenous patient group (Scott, 1988). The studies which Dr Cowen praises are flawed for a number of reasons, including insufficiently stringent diagnostic criteria (Coppen *et al*, 1963), small numbers, and 'open' treatment regimes (Barker *et al*, 1990). Similarly, tryptophan discontinuation studies of an open nature may encourage the generation of hypotheses, but do not permit an unbiased appraisal of the merits of treatment.

Eosinophilia-myalgia syndrome is a serious illness, which carries an appreciable mortality. Although the association of EMS with L-tryptophan may ultimately prove to be either indirect or tenuous, its advent does at least allow some time for reflection on the limited evidence for efficacy of L-tryptophan in the treatment of depression.

DAVID BALDWIN
PAUL COSFORD

St Mary's Hospital
Praed Street, London W2 1NY

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Research by junior doctors

DEAR SIRS

It was refreshing to read Drs Guthrie & Black's view of research from the standpoint of the junior psychiatrist (*Psychiatric Bulletin*, December 1990, **14**, 719–720). I believe, however, that they have tactfully understated the difficulties. These are:

(a) 'good' research takes too long and is too time-consuming to be incorporated in the training programme
(b) a target of publication leads to an almost impossible standard of methodology
(c) an approach to most academics leads to a catalogue of difficulties which stultifies enthusiasm.

The result of these difficulties is that research, with few exceptions, is postponed to the senior registrar phase of training. I would propose that SHOs and registrars should be allocated, yes allocated, small studies or experiments which would take no more than nine months to complete while pursuing a standard training course. If such projects produced encouraging results they could be expanded into 'good' research at the senior registrar stage. Meanwhile, they would introduce the junior doctor to the excitement of the unknown and once the original hurdle of doing a research project is surmounted,