Making clinical informatics work

EDITOR,—We do not agree with Paul Lelliott's view that no existing hospital information system works.[1] At Burton Hospitals NHS Trust we have a totally integrated hospital information support system, which has been operating since April 1992. It provides many benefits for patients' care and for the wide range of staff who use it. We have married clinical activity (except for the doctor's record) with electronic recording on a hospital-wide basis and are now looking towards including doctors' notes.

Our system is clinically biased as it is used by all clinical staff; it also provides all the information needed for administration, management, and contracting as a byproduct. It is used by all junior medical staff, 98% of consultant staff, and nurses and other paramedical staff, and the demand for more terminals is a measure of its popularity. It is also used by managers and the contracting team. Our junior staff worry how they will manage at hospitals without the system.

Our project was not financially supported by the centre; there was a heavy commitment from doctors and other clinical staff, all of whom helped to select and implement the system. This created the sense of ownership so necessary for the project to succeed.

The system was supplied by MEDITECH, whose staff worked with us to provide the information system and have the insight to keep producing enhancements to get closer to the total electronic record talked about by so many.

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1 Lelliott P. Making clinical informatics work. *BMJ* 1994;308: 802-3. (26 March.)

Antidepressants and suicide

EDITOR,—Göran Isacsson and colleagues examined the use of various antidepressants among people who committed suicide and concluded that therapeutic failure may be a greater problem than toxicity.[1] They state that they refrained from ranking different drugs, but this occurred in practice because the differences found were explained on the grounds of the weaker antidepressive effect of the newer drugs, moclobemide and mianserin. The basis for the authors' conclusion was that, despite their relatively low toxicity, both drugs were overrepresented in the people who had committed suicide compared with their use in general.

The rate of suicide in Finland is among the highest in the world.[2] To obtain more effective means of preventing suicide a one year nationwide study was conducted during 1987-8. During the year of the study 1397 suicides were committed; toxicological screening was performed in 1348 cases. All antidepressants sold at that time in Finland were screened for (mianserin was on the market, but not moclobemide). Antidepressants were found in 38 cases (amitriptyline 16, doxepin seven, maprotiline eight, mianserin two, and others five) among 1083 suicides committed by means other than poisoning. When these figures are correlated with the sales of the corresponding drug the risks are opposite to those reported by Isacsson and colleagues: 16·6, 4·7, 3·9, and 2·0 cases/defined daily dose/1000 inhabitants/day for maprotiline, amitriptyline, doxepin, and mianserin respectively.

Other explanations besides effectiveness are possible for the results obtained in the Swedish study—for example, not all people who commit suicide are depressed, not all depressed patients are treated with antidepressants, and patients might have been selected according to a particular drug. The last mentioned reason is more critical in the case of a new drug. Moclobemide was introduced into the Swedish market in 1989 and mianserin in 1990, and the study period was 1990-1. Moreover, to the best of our knowledge, at that time in Sweden moclobemide was considered to be a second line drug, which might be tried after failure of other drugs.

A more informed view on the debits and credits of the management of depression has been presented by Henry.[3] His scheme of the fate of a depressed patient takes all critical points into consideration: diagnosis, treatment, compliance, and response. Toxicity is only one of the problems associated with antidepressants; at least in Finland, that is not only a marketing argument but also a genuine concern. In 109 fatal cases of poisoning with antidepressants in Finland during 1992 the most important toxicological finding was amitriptyline in 38 cases and doxepin in 38 cases; of the new drugs, citalopram was found in eight cases, moclobemide in eight, and mianserin in two. The difference in toxicity is well documented.[4,5]

We have doubts about the validity of a post-mortem study on the antidepressant effect of drugs, even in the case of suicidal depression. Our point of view is a clinical one. Whether some drugs are relatively more effective than the others in treating depression or preventing suicide requires properly designed clinical and prospective studies.

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1 Isacsson G, Holmgren P, Wasserman D, Bergman U. Use of antidepressants among people committing suicide in Sweden. *BMJ* 1994;308:506-9. (19 February.)
2 World Health Organisation. *Causes of death 1990.* Geneva: WHO, 1991.
3 Henry JH. Debits and credits in the management of depression. *Br J Psychiatry* 1993;193(suppl 20):33-9.
4 Cassidy S, Henry J. Fatal toxicity of antidepressant drugs in overdose. *BMJ* 1987;295:1021-4.
5 Vuori E, Ruohonen A, Penttilä A, Klaukka T, Lahti T. Fatal poisonings with antidepressants in Finland 1985-1987. *Acta Psychiatr Scand* 1989;80(suppl 354):55-60.

Teaching medical students about disability

EDITOR,—In her editorial on teaching medical students about disability Alleyna Claxton is right to suggest that those affected by disability should be consulted.[1] ParentAbility, a self help support group within the National Childbirth Trust, is one group that medical colleges should approach to ensure that the attitudes, skills, and knowledge learnt during training are focused on meeting the needs of people who use services. ParentAbility's contact register includes about 400 mothers, and some fathers, with arthritis, cerebral palsy, spina bifida, epilepsy, multiple sclerosis, myalgic encephalomyelitis, and visual and hearing impairments as well as a number of rarer disabilities and problems arising from accidents and polio. The network is a rich resource and is currently contributing to the training of a range of health professionals, including student midwives in Northampton, Basingstoke, and Oxford. Any medical colleges wishing to contact the group should write to ParentAbility, National Childbirth Trust, Alexandra House, Oldham Terrace, London W3 6NH.

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1 Claxton A. Teaching medical students about disability. *BMJ* 1994;308:805. (26 March,)

Rational prescribing

EDITOR,—It is unfair that the Audit Commission should put the blame for the cost of medicines and prescribing on to general practitioners.[1] Pharmaceutical prices are agreed with the pharmaceutical companies and the Department of Health through the Pharmaceutical Price Regulating Scheme. The department is responsible both for the cost effective use of drugs in the NHS and for the welfare of the British pharmaceutical industry. The department therefore has conflicting aims. Any downward pressure on expenditure through doctors' prescribing will be countered by price increases agreed with drug companies through the price regulation scheme. Of course, profits earned from drugs by pharmaceutical companies go towards research into new medicines. To support research by the pharmaceutical companies at the present level any reduction in the cost of expensive drugs must inevitably lead to an increase in the cost of the cheaper ones.

The overall cost to the NHS of pharmaceutical products is not in the hands of general practitioners but is controlled by the Department of Health through the Pharmaceutical Price Regulating Scheme.

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1 Tonks A. GPs' prescribing is irrational, says Audit Commission. *BMJ* 1994;308:675. (12 March.)

Sumatriptan

EDITOR,—According to extensive clinical trials, sumatriptan combines high efficacy with good tolerability and safety in acute attacks of migraine.[1] Although it has not shown any addictive properties in short term and long term safety studies, we report on seven patients with a longstanding history of migraine in whom misuse of sumatriptan developed. One similar case has been reported recently.[2]

The seven patients (five women, two men) were aged 47-65 (average 54) and attending specialist headache clinics. Two had migraine with aura and five had migraine without aura.[3] The average age at onset of the condition was 20 (range 14-25). All patients had chronic daily headache and used sumatriptan daily or almost daily (four took it orally and three subcutaneously; they took 15-60 (average 32) doses a month). All patients had previously suffered from drug induced headache (average duration 10 years) caused by ergotamine (one patient), analgesics (three), and mixed ergot-analgesic preparations (three).

Four patients had previously undergone one or more attempts at withdrawal of analgesics or ergotamine compounds. The patients switched from misuse of analgesics or ergotamine to misuse of sumatriptan within one week to 36 months (average nine months). In all cases sumatriptan led