LETTERS TO THE EDITOR

M. Venkataswamy Reddy's & C.R. Chandrashekar's Reply

Sir,

We are grateful to Dr. M. Meghachandra Singh and Dr. S.C. Pradhan for their interest and comments on the article 'prevalence of mental and behavioural disorders in India: a metaanalysis'. In five studies where the target populations and sampling techniques for selection of study areas were not specified, their combined sample had sex ratio of 978, children below 15 years of age constituted 45.8% and aged 60 years and above constituted 4.6%. The respective figures for the combined sample of four studies where the populations were based on convenience, were 909, 36.8% and 6.9%. As per 1981 census, the respective figures were 933, 39.6% and 6.5%. These age and sex distributions of the combined samples in the two groups of studies can be considered as fair representation of Indian population. Two studies on tribals and one study on slum people represented their respective segments of Indian population.

Checking for variation in prevalence rates reported in West Bengal, the response error where the head/housewife were interviewed, and utility of own diagnostic tools formed an important step in the validation of the obtained results. Separate prevalence rates were worked out based on the studies specified by each of the criteria mentioned, as shown in annexure.
Mania and endogenous depression were significantly high ($p < 0.01$), while neurotic depression, alcohol/drug addicts and behavioural/emotional disorders were low in the combined sample of studies carried out in West Bengal. Lowest overall prevalence rate of 48.2 were obtained in the group of studies where the family head/housewife were interviewed. This was mainly due to the under reporting of all types of neurotic disorders and endogenous depression. Though there were five studies in this group, the estimates of neurotic disorders were based on only two studies and the rest were on priority mental disorders. Further analysis showed that the prevalence rates reported for neurotic disorders were not significantly effected by the inclusion of these two studies. The own diagnostic tools under reported manic depression, neurotic depression and alcohol/drug addicts, and over reported endogenous depression and mental retardation. Thus, none of these groups of studies exhibited significantly low prevalence rates for all the disorders.

The identification of organic psychosis was improved in the studies conducted after 1985. The metaanalysis technique applied consisted in estimating the separate prevalence rate for each disorders and sum for all disorders in order to arrive at a precise overall estimate for mental and behavioural disorders. Thus, the studies on priority mental disorders influenced the estimates of prevalence rates of these disorders only.

The meta analysis may be helpful in generating hypotheses regarding the diagnostic criteria itself. For example, the reporting of manic depression and endogenous depression in Table 3 were mutually exclusive in eleven out of thirteen studies, indicating poor distinguishability between these two distinct diagnostic categories. A well designed nationwide multicentric study is necessary, but may not be feasible mainly due to expense. Moreover the morbidity variation was mainly due to the rural and urban sectors and sex difference. Among other things, inclusion of ICD diagnostic criteria and enquiry of each individual family members separately to collect the information form important requirements for a mental morbidity study to be considered for metaanalysis in future.

As final clarifications, the sample sizes in each row in table 2 of the original article can be obtained by dividing the number of cases by the prevalence rate and multiplying the result by 1000. The mean presenting age of a disorder was defined as the mean age of patients suffering from the disorder at the time.
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of onset of the illness.

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RISPERIDONE AUGMENTATION OF CLOZAPINE

Sir,

Henderson and Goff (1996) in an open trial reported augmentation of clozapine's effect with risperidone in schizophrenic patients not responding to clozapine alone. There are no reports in literature of controlled trials or on long term effectiveness of this combination. In this report a case has been described which shows the long term effectiveness of this combination in resistant schizophrenia.

CASE REPORT

Mr. S, 53 years old male diagnosed as a case of paranoid schizophrenia at the age of 23 years. He was started on clozapine in 1995 as he developed resistance to classical neuroleptics. His dose was gradually increased upto 600mg/day over a period of one year. Because of frequent recurrence of symptoms clozapine was augmented with risperidone in September 1997. Risperidone was started with 2 mg/day and gradually increased to 6 mg/day in four weeks. His symptoms gradually improved on this combination. During one and half years of follow up he had two short lasting episodes of behavioural abnormality characterised by restlessness, increased smoking and disturbed sleep which responded to addition of 10 mg of diazepam which was tapered off in four weeks each time. Psychotic symptoms did not recur. No significant adverse effect was observed.

This combination is safe and effective in long term. Risperidone augmentation of clozapine should be tried in cases not responding to clozapine. However, this is a single case report, studies are needed to see the effectiveness and safety of this combination.

REFERENCES

Henderson, D.C. & Goff, D.C. (1996) Risperidone as an adjunct to clozapine therapy in chronic schizophrenics. Journal of Clinical Psychiatry, 57, 395-397.

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CORRIGENDUM

"Geropsychiatric Morbidity in Rural Uttar Pradesh" by S.C. Tiwari & Shrikant Srivastava in October 1998 issue of Indian Journal of Psychiatry.

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