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TO THE EDITOR: Dr. Sachs et al. conducted a 3-week double-blind, randomized, placebo-controlled study of risperidone or haloperidol augmentation of a mood stabilizer in bipolar patients with a current manic (N=123) or mixed (N=33) episode. They found that the antipsychotic drugs conveyed benefits in patients with mania but not in those with mixed illness. From my experience, the latter finding is hard to accept. I suggest that it arose because the authors did not examine early benefits with antipsychotic drugs and/or used insensitive measures to assess treatment gains.

With reference to the former possibility, the authors compared treatment gains at the 3-week endpoint but not, for instance, during the first week; this is not a trivial issue because every additional day that a patient is disturbed adds to the risk of illness-related harm to the self or environment. With reference to the latter possibility, the authors did not examine whether nonviolent self- and environment-damaging acts resulting from impaired judgment were reduced by antipsychotic augmentation. If the sizes of individual groups were too small for analysis, the drug groups could have been combined to determine whether antipsychotic treatment, per se, is helpful early or otherwise during a mixed episode.

Of note, if the authors are right that risperidone or haloperidol augmentation of mood stabilizers is unhelpful in mixed illness, then olanzapine augmentation may be worth considering. Tohen et al. (1) found that olanzapine attenuated both manic and depressive symptoms and that the gains were greatest in valproate-treated patients with mixed illness.

#### Reference

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### Traffic Accidents and Friday the 13th

TO THE EDITOR: A recent article in the *Journal* by Simo Näyhä, M.D., Ph.D. (1), is of interest. However, there is clearly an error in the interpretation of the data. The national cause-of-death files of Finland provided information on deaths due to traffic accidents, but no distinction was made in the article between the day of the accident and the day of the death. It is highly likely that many of the people who died on Friday the 13th due to a traffic accident were actually injured before that day. Therefore, the main conclusion drawn in the article—namely, that women are more prone to having a fatal traffic accident on Friday the 13th than on other days of the year—may be

false. On the other hand, it would still be valid to conclude from the findings that women who have been in a traffic accident are more prone to die on Friday the 13th than on other days. If so, then superstition could be having an effect on the vital bodily functions of women rather than on women's behavior in traffic.

#### Reference

1. Näyhä S: Traffic deaths and superstition on Friday the 13th. *Am J Psychiatry* 2002; 159:2110–2111

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### Dr. Näyhä Replies

TO THE EDITOR: I thank Dr. Smith for his comments. Some of the women who died on Friday the 13th were, of course, injured some days previously. This would not invalidate my argument. It is sufficient that in some proportion of the cases, the accident and the death occurred on the same day. During the 1970s, 75% of the people killed as a result of traffic accidents in this country died at the scene of the accident or en route to the hospital (1), and an additional proportion died in the hospital on the same day. The percentage of more or less immediate deaths may have declined now because of improved emergency services, but more recent data are difficult to come by. In Denmark, where distances are short, 68% of the persons who died in traffic in 1986–1991 were dead upon arrival at the emergency unit, and 88% died within the first day (2). Comparable proportions of quick deaths in this case would be sufficient to provide a sound basis for the conclusion reached in my article.

The suggestion that superstition-related anxiety might cause a degradation in vital bodily functions is interesting but would presuppose a higher risk due to Friday the 13th in older age groups than in younger ones. A reanalysis of female deaths broken down into the age bands of 15–34, 35–54, 55–74, and ≥75 years showed risk ratios of 2.51 (95% confidence interval [CI]=1.45–4.36), 1.26 (95% CI=0.59–2.70), 1.32 (95% CI=0.74–2.36), and 1.36 (95% CI=0.54–3.44), respectively. Since an elevated risk was more typical of young women who have less driving experience, an explanation based on driving errors would seem more likely.

Possible flaws, listed in the article, include deaths of passengers, who obviously cannot be part of the causal chain, and it is also difficult to see why drivers (men or women) beset by this superstition would select women as their victims. Dr. Smith presents an additional problem that cannot be solved without a large study linking accidents to subsequent deaths. So far, any explanations must remain speculative.

#### References

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2. Madsen FQ, Hartmann-Andersen JF: [Fatal traffic accidents in Denmark: survival time and factors of importance for the pre-hospital phase.] *Ugeskr Laeger* 1996; 158:5432–5437 (Danish)

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