ment (2). The newer anticonvulsant oxcarbazepine represents a prodrug of 10-OH-carbamazepine, the active metabolite of carbamazepine, and shows even better tolerability. So far, it has been investigated only in the treatment of affective disorders.

We report an open-label case series of six male inpatients (mean age=29.8 years, SD=9.1) who had minimal or no response to antipsychotic treatment throughout 6 weeks of treatment and were not given clozapine for various reasons. Written informed consent was obtained in all cases. All patients were taking the maximum tolerated dose of the respective antipsychotic drug with sufficient plasma levels (initial treatment: one taking olanzapine, 20 mg/day; one, amisulpride, 600 mg/day; four, quetiapine 500–900 mg/day). They were monitored with use of the Brief Psychiatric Rating Scale (BPRS). Oxcarbazepine was added to antipsychotic treatment, starting with 300 mg/day and ending with a final dose of 900 to 2100 mg/day (mean=1500 mg/day, SD=465), with a transient headache as a side effect in a single case.

BPRS scores were decreased significantly from baseline (mean=58.7, SD=12.8) after 42 days of adjuvant treatment (mean=36.3, SD=9.2) (p=0.007, Student's t test).

Despite their limitations, these data raise preliminary evidence for the adjuvant effects of oxcarbazepine in the acute treatment of schizophrenia. There is no relevant pharmacokinetic interaction between olanzapine, amisulpride, or quetiapine and oxcarbazepine (3, 4). Thus, the clinical synergism is most likely due to pharmacodynamic effects. The good tolerability of oxcarbazepine may have benefit in both treatment-resistant and acutely ill patients with slow treatment response.

References

1. Weiden P, Aquila R, Standard J: Atypical antipsychotic drugs and long-term outcome in schizophrenia. J Clin Psychiatry 1996; 57(suppl 11):53–60
2. Dose M, Apelt S, Emrich HM: Carbamazepine as an adjunct of antipsychotic therapy. Psychiatry Res 1987; 22:303–310
3. Natsch S, Hekster YA, Keyser A, Deckers CLP, Meinardi H, Renier WO: Newer anticonvulsant drugs: role of pharmacology, drug interactions and adverse reactions in drug choice. Drug Saf 1997; 17:228–240
4. Keck PE Jr, McElroy SL: Clinical pharmacodynamics and pharmacokinetics of antimanic and mood-stabilizing medications. J Clin Psychiatry 2002; 63(suppl 4):3–11

F. MARKUS LEWEKE, M.D.
CHRISTOPH W. GERTH, M.D.
DAGMAR KOETHE, M.D.
JOHANNES FAULHABER, M.D.
JOACHIM KLOSTERKÖTTER, M.D.
Cologne, Germany

Pitfalls of Meta-Analyses

TO THE EDITOR: In recent years, psychiatry has been relying to an ever-increasing extent on meta-analyses to infer the efficacy of psychiatric treatments. Meta-analysis is a useful tool for integrating data from different studies using similar treatments on similar patients. Consequently, meta-analyses provide the field with an estimate of the effect size of a treatment. Many assumptions are made in meta-analysis; among the most important are that studies of comparable quality be included in the meta-analysis, that study quality be weighed in the computation, and that sample sizes be roughly comparable. Besides statistical issues, there are assumptions that in order to be accurate a meta-analysis must include all relevant research studies and be based on studies that have comparable patient populations.

Although Leichsenring and Leibing (1) attempted to do a conscientious job of comparing the efficacy of dynamic therapy to cognitive therapy in patients with personality disorders by using meta-analytic techniques, they failed to include several studies: two of avoidant and obsessive-compulsive personality disorder (2, 3) and one of borderline personality disorder (4). In addition, they did not include any studies involving group therapy. Omitting relevant studies when so few are available raises questions not only about the generalizability of this meta-analysis but also about the technology and methods used in selecting studies for inclusion. Thus, we strongly recommend that meta-analysts describe the exact terms used in searches and that searches using similar terms be conducted across different databases. There are limitations to blind computerized searches; therefore, searches must be supplemented by, for example, looking at references of relevant articles and by contacting experts.

Although we sympathize with the wish to examine the effectiveness of different psychotherapy systems for patients with personality disorder, there is a clear limitation of lumping together studies looking at the efficacy of treatment for so many different kinds of patients. It could be that instead of having found support for the dodo bird verdict (psychotherapeutic equivalence), these studies could show that different therapies are better at helping patients with different personality disorders. Therefore, the lack of apparent differences between treatments might, for example, be due to the possibility that cognitive therapies are more effective with patients with avoidant personality disorder, while interpersonal/dynamic therapies might be more effective with obsessive-compulsive personality disorder.

References

1. Leichsenring F, Leibing E: The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis. Am J Psychiatry 2003; 160:1223–1232
2. Barber JP, Morse JQ, Krakauer ID, Chittams J, Crits-Christoph K: Change in obsessive-compulsive and avoidant personality disorders following time-limited supportive-expressive therapy. Psychotherapy 1997; 34:133–143
3. Barber JP, Muenz LR: The role of avoidance and obsessiveness in matching patients to cognitive and interpersonal psychotherapy: empirical findings from the Treatment for Depression Collaborative Research Program. J Consult Clin Psychol 1996; 64:951–958
4. Clarkin JF, Foelsch PA, Levy KN, Hull JW, Delaney JC, Kernberg OF: The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. J Personal Disord 2001; 15:487–495

JACQUES P. BARBER, PH.D.
BARBARA MILROD, M.D.
Philadelphia, Pa.

Elevated Homocysteine Levels in Schizophrenia

TO THE EDITOR: With great interest, we read the report on elevated homocysteine levels in young male patients with