As mentioned by the authors, some drug abusers fabricate sleep symptoms to obtain psychostimulants.

Although narcolepsy cannot be diagnosed based on the Multiple Sleep Latency Test alone, a properly performed Multiple Sleep Latency Test can help to confirm the diagnosis (2). Drs. Krahn and Gonzalez-Arriaza discussed some of the challenges of performing the Multiple Sleep Latency Test in a suspected narcoleptic patient. For example, in the excellent case presented, the authors appropriately adjusted the timing of the Multiple Sleep Latency Test and the preceding polysomnogram to accommodate the patient's delayed sleep phase (3). However, their patient also had a short habitual total sleep time of approximately 5 hours, as documented by 1 week of wrist actigraphy. The fact that the patient was able to obtain 7.2 hours of sleep during the nocturnal polysomnogram suggests that he may have insufficient sleep syndrome, possibly associated with inadequate sleep hygiene.

At the University of Mississippi Sleep Disorders Center, we emphasize to our patients the importance of allowing sufficient time for sleep by spending at least 8 hours per night in bed in the week preceding a Multiple Sleep Latency Test. Usually a sleep log is used to document the preceding week's sleep. We commend the authors on the use of more objective wrist actigraphy, which documented a chronically insufficient sleep time but question assigning the diagnosis of narcolepsy to a patient with apparent chronically insufficient sleep.

As Drs. Krahn and Gonzalez-Arriaza illustrated in this case, the diagnosis of narcolepsy must be based on a combination of history, examination, and overnight polysomnogram findings, in addition to the Multiple Sleep Latency Test. As is known, the results of a Multiple Sleep Latency Test are influenced by the quantity and quality of the preceding 7 nights of sleep (3). Chronic sleep deprivation can mimic narcolepsy on a Multiple Sleep Latency Test. Accordingly, we wonder about the possibility that the Multiple Sleep Latency Test results in the case presented were affected by an accumulated sleep debt that could not be more than partially compensated for by the 7.2 hours of nocturnal sleep preceding the test.

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Drs. Krahn and Gonzalez-Arriaza Reply

TO THE EDITOR: We appreciate the comments of Dr. Rack and colleagues that remind us of the importance of interpreting sleep laboratory test results in a clinical context. We agree that the Multiple Sleep Latency Test is a valuable diagnostic tool. Nonetheless, the role of the clinician is to correlate the Multiple Sleep Latency Test findings with the patient's clinical presentation. In this instance, the presence of long-standing excessive daytime sleepiness, spells consistent with clear-cut cataplexy, sleep paralysis, and vivid dreams greatly increased the likelihood of narcolepsy. We concur that the sleep testing was performed under less-than-optimal conditions in view of the patient's delayed sleep phase and chronic partial sleep deprivation. If the patient's symptoms had been limited to excessive daytime sleepiness, the Multiple Sleep Latency Test findings would have been less persuasive. In the presence of the classic tetrad of narcoleptic symptoms and given that the Multiple Sleep Latency Test results were dramatically abnormal (mean initial sleep latency of 30 seconds and sleep onset of REM sleep at all four naps), we believe that this test confirmed the clinical diagnosis of narcolepsy with cataplexy (1).

Many patients with narcolepsy are now recognized to have sleep maintenance difficulties, which sometimes makes performing a Multiple Sleep Latency Test under optimal conditions, while desirable, at times difficult to achieve. Relying solely on the clinical assessment for establishing the diagnosis of narcolepsy, in our opinion, is not sufficient. The relative lack of physician education regarding narcolepsy, the wide range of cataplectic spells, and the potential need after diagnosis to provide lifelong treatment with medications with abuse potential underscore the need for as much objective data as possible.

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Suicide Among Physicians

TO THE EDITOR: The article by Eva S. Schernhammer, M.D., and Graham A. Colditz, M.D., D.P.H. (1), is the first meta-analysis of suicide rates among physicians, to our knowledge, and is therefore most welcome.

The authors conducted electronic searches in four databases: MEDLINE, PsycINFO, AARP Ageline, and EBM Reviews Cochrane Database of Systematic Reviews. To conduct a comprehensive and systematic literature search, several databases should be used. In psychiatry, it is recommended to include at least Embase (Excerpta Medica) and Biosis (Biological Abstracts) in addition to MEDLINE (Index Medicus) and Psyclit/PsycINFO (Psychology Abstracts) (2). We would also recommend the Web of Science (http://www.isinet.com/products/citation/wos). Variations in the overlap between databases and the high proportion of journals indexed in only one of the databases emphasize the importance of searching all that we mentioned to ensure optimal coverage of the relevant literature (2, 3).

Drs. Schernhammer and Colditz concluded that since many studies were conducted more than a generation ago, there was a need for more recent studies. We recently published a nationwide study from Norway covering the period 1960–2000 (4). A total of 98 suicides among male physicians and 13 suicides among female physicians were studied. Suicide rates among physicians increased from the 1960s to the

1980s. However, in the 1990s, the rates were significantly lower than in the 1980s among male physicians, other university graduates, and the general population. Nevertheless, in the 1990s, physicians still had a higher suicide rate than other university graduates and the general population, both among men (43.0 per 100,000 person-years; 95% confidence interval [CI]=35.3–52.5) and women (26.1 per 100,000 person-years; 95% CI=15.1–44.9) compared to 23.5 per 100,000 person-years (95% CI=23.1–24.0) and 8.0 per 100,000 person-years (95% CI=7.8–8.3) among male and female nongraduates, respectively.

The suicide rate among female physicians was twice as high as that of the general population as well as other female graduates, even in the 1990s. Of interest, suicide rates increased steeply by age among physicians and other graduates, whereas for nongraduates, the rate was highest among those ages 40–60 years. Drs. Schernhammer and Colditz emphasized the elevated suicide rates among female physicians. However, the higher suicide rates among elderly physicians are also of concern and warrant further investigation.

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