

patients were left without any medication for 2 months, and during this phase, all the potential patients who were more likely to have relapsed were dropped from the study. Sixty-one subjects (16%) discontinued treating during this phase. It clearly raised doubts as to whether the authors introduced bias at this stage by using an open placebo arm for 2 months. Additionally, the authors restricted the inclusion criteria and excluded depressed patients who had anxiety. However, in day-to-day clinical practice, we have a large proportion of patients who have depression with anxiety. The results of this study may not be applied to this group of patients. In light of these issues, it will be unreasonable to conclude that sertraline is significantly effective in the preventive recurrence of depression compared to placebo.

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#### Psychiatry and General Practitioners

TO THE EDITOR: Frederick S. Sierles, M.D., et al. (1) showed that future psychiatrists score higher than other medical students on measures of psychiatric knowledge and verbal reasoning and lower on other topics. They then concluded that more attention should be paid to the general medical education of psychiatrists. We question how the authors interpreted their data. The scores on the measures of learning were standardized. Therefore, if some people do better, then some must do worse. Given this obvious situation, isn't it better for future surgeons to perform above the mean on surgical subjects, future internists in general medicine, and future psychiatrists in psychiatry? Much, if not all, of the differences in Medical College Admission Test and U.S. Medical Licensing Examinations scores most likely can be attributed to student preferences and interests at baseline and the clinical content of the first postgraduate year.

The public health consequences and likelihood of making medical errors because of poor training are different for psychiatrists and nonpsychiatrists. About 20% of the patients seeing primary care physicians have a significant mental disorder (2). Only 23% of the patients with depression treated by primary care physicians received an antidepressant, of whom many receive an insufficient dose (3, 4). Missed psychiatric diagnoses and undertreatment of those properly diagnosed by a primary care physician are serious problems. Is the converse true for psychiatrists? This has not been shown. Most psychiatric patients, we would imagine, have been evaluated and are treated by primary care physicians for any general

medical condition before they see or are referred to a psychiatrist. Psychiatrists should advise a patient who has not been seen recently by a primary care physician to do so. Psychiatric patients routinely see primary care physicians; patients seeing primary care physicians do not routinely see psychiatrists. It seems to us that the urgent need is not for future psychiatrists to learn more general medicine but for future primary care physicians to learn more psychiatry.

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#### Psychotropic Medication and Stroke Outcome

TO THE EDITOR: The number of elderly people will increase dramatically in the next few years. Many of them are given prescriptions for psychotropic drugs, such as antidepressants, antipsychotics, and hypnotics, to treat behavioral disturbances related to dementia. The same elderly patients are at a high risk of cerebrovascular events, which potentially could be exaggerated by concomitant psychotropic medications. A report (1) suggested that risperidone possibly increases the risk of cerebrovascular adverse events in the elderly. There is now a concern that discontinuation of risperidone may lead to a switch to conventional antipsychotic drugs, such as haloperidol (2), which is known to retard functional recovery after cerebrovascular events (3).

We have studied the safety of risperidone in aged male rats subjected to small cortical stroke. The experimental design tried to model clinical practice in which elderly patients who have sustained a small focal stroke or who are at a high risk of stroke are given psychotropic medication. The rose bengal model was selected to produce a cortical infarct in rats because the brain pathology is well characterized, the cortical lesion produced is consistent, and the lesion has a precise location and size. Aged rats were used since they might be more vulnerable to brain insults acutely and chronically. The rats were treated daily with risperidone before and for 3 weeks after ischemic injury. To assess neural and functional outcome, we used a new ledged-beam walking test that can detect motor deficits with a high sensitivity and a challenging match-to-place water maze test, followed by histological analyses.

Risperidone transiently worsened behavioral impairments during drug exposure but did not affect the extent of tissue damage or long-term functional outcome. This is consistent