Treatment of Psychosis in Lewy Body Disease

TO THE EDITOR: Considering their experience in the management of advanced Lewy body disease (1), it was surprising that in their review of the challenging convergence of neuropsychiatric comorbidity, published in the October 2007 issue of the *Journal*, Daniel Weintraub, M.D., and Howard I. Hurtig, M.D., (2) omitted electroconvulsive therapy (ECT)—a treatment that can address both psychosis and movement disorder and avoid a host of medication-related side effects without coupling improvement in one realm of symptoms with exacerbation of the other. Along the lines of other potentially beneficial interventions supported by clinical experience but lacking definitive evidence from scientific trials, perhaps a note pertaining to antipsychotic response to serotonin (5-HT_3) antagonist ondansetron in such cases should be included as well (3).

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Dr. Rasimas reports no competing interests.

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Drs. Weintraub and Hurtig Reply

TO THE EDITOR: We appreciate Dr. Rasimas' thoughtful observation that ECT should be considered as a treatment option for the neuropsychiatric complications of Lewy body disease. Specifically, there is evidence of ECT's effectiveness in the treatment of depression in Parkinson's disease (1)—often accompanied by temporary improvement in the motor symptoms of Parkinson's disease—as well as limited case literature (2) suggesting that it may also be effective in treating psychosis in the disease. In addition, anecdotal experience suggests that ECT may improve agitation in the context of dementia in Parkinson's disease, with psychosis often being a component of this clinical syndrome. We agree that ECT can play a role in this setting, but only when the neuropsychiatric symptoms are medically intractable.

Regarding the use of other pharmacologic treatments for psychosis in Parkinson's disease and dementia with Lewy bodies, Dr. Rasimas references the positive results of a 1995 open-label study (3) of ondansetron, a 5-HT_3 antagonist, for the treatment of psychosis in advanced Parkinson's disease. To our knowledge, this study has not been replicated. Furthermore, the high cost of ondansetron is a major drawback compared with more affordable and relatively safe atypical antipsychotics (e.g., quetiapine and clozapine).

Regarding other evidence in support of the role of the serotonergic system in these disorders, there is case literature suggesting that selective serotonin reuptake inhibitors may have antipsychotic properties in both Parkinson's disease (4, 5) and dementia with Lewy bodies (6).

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Witnessing Horror at the World Trade Center

TO THE EDITOR: The study reported by Megan A. Perrin, M.P.H., et al., published in the September 2007 issue of the *Journal* (1), involved a methodologic decision which may have resulted in the loss of some clinically important data and an underestimate of the traumatogenic experiences of firefighters.

The article stated that "witnessing horror," one of the variables studied for its effects on the prevalence of probable posttraumatic stress disorder (PTSD), "was defined as witnessing any of the following: an airplane hitting the World Trade Center, a building collapsing, people running from a cloud of dust/debris, individuals being injured or killed, or people falling or jumping from the World Trade Center towers" (1, p. 1387). These experiences are surely horrific, but the list includes only events at the time of the collapse.

As noted in the Cohort section, work at the World Trade Center site continued for nearly 9 months after the collapse. During that time, members of the New York City Fire Department performed the bulk of the recovery work and were repeatedly exposed to horrific scenes of decaying and dismembered human remains. In the early days of the recovery effort, firefighters often had to disassemble corpses in order to remove them from the wreckage before they burned. In later

months, the remains they found were in states of increasing decomposition. All these conditions contributed to the cumulative traumatic effect of the ongoing World Trade Center experience and may help to explain the greater prevalence of PTSD found among firefighters than among other groups, such as the police.

In my capacity as staff psychiatrist for the New York City Fire Department's Bureau of Health Services and Counseling Services Unit, I have had occasion to interview and treat hundreds of firefighters traumatized by their experiences at the World Trade Center. While large-scale bereavement and threats to personal safety were surely traumatic for them, it is the horrific experiences of the recovery period in the months after the collapse itself that regularly appear in their nightmares and flashbacks.

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Ms. Perrin Replies

To The Editor: Dr. Kelly's comments highlight the importance of repeated exposure to gruesome situations in the risk of PTSD and provide a greater understanding of the personal experiences of the firefighters who responded to the World Trade Center disaster. He suggests that our study failed to assess a key risk factor for PTSD: the handling of human remains while working at the World Trade Center site. It is true that this was not included in our definition of witnessing horror. Our assessment of witnessing horror focused on events that happened on the morning of September 11, 2001, which we referred to in our article as "within-disaster experiences." These exposures were distinguished from work experiences because they most likely represent a higher degree of life threat. In our study, handling body remains was indirectly assessed as a part of work experiences by asking individuals whether they performed hand digging and search and rescue activities while working at the site.

In the study's full cohort of rescue recovery workers and volunteers, hand digging was indeed associated with increased risk of developing PTSD (adjusted odds ratio=1.2 [95% confidence interval=1.1–1.4]), whereas search and rescue was not. However, neither hand digging nor search and rescue significantly increased the risk of PTSD in firefighters. We understand that this is a relatively crude assessment of the handling of gruesome body remains, and thus we cannot definitively determine the impact of handling body remains from this study. Within a clinical setting, it may be possible to gain a greater understanding of an individual's personal reaction to gruesome experiences than in a quantitative telephone survey. While standardized surveys do not provide the opportunity to ask more detailed or individualized questions regarding particular exposures, they are effective at assessing a consistent set of exposures across large samples.

The primary goal of our study was to examine differences in PTSD prevalence among occupation groups and to determine whether PTSD risk was associated with within-disaster and work-related experiences. We were able to determine that performing rescue activities outside of one's training was an important risk factor for PTSD, and rates were higher across different occupations, independent of experiences. These findings suggest that disaster preparedness training may reduce the psychological burden in future responders. The impact of personal experiences, as described by Dr. Kelly, can only be assessed by clinicians. Their insight, in collaboration with epidemiological evidence, is critical to improving treatment and prevention of PTSD.

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Antidepressants in the Postpartum Period: Additional Considerations

To The Editor: We read with interest the article by Jennifer L. Payne, M.D., published in the September 2007 issue of the *Journal*, on practical considerations of antidepressant use postnatally (1). However, as developers of the United Kingdom National Clinical Guideline on Antenatal and Postnatal Mental Health (2), we found the article to be inaccurate in several respects.

We agree that maintaining drugs started during pregnancy in the postnatal period is appropriate but feel that this means that paroxetine, although virtually undetectable in breast milk, should not be given to a woman who wishes to breastfeed, given the concern over its safety in pregnancy (3, 4) and the possible difficulties on withdrawal.

While monitoring a breastfed infant is important, the additional point should be made that neonates whose mothers took antidepressants during pregnancy should also be monitored both for symptoms of withdrawal from the drug and for serotonergic toxicity syndrome (the symptoms are similar) (2, 5).

After a careful review of the available data, we concluded that "indicated" prevention may benefit women with subthreshold symptoms of depression or anxiety, although the Cochrane review on the prevention of postnatal depression concluded that this is not effective (6). Evidence on the risk to the fetus of chronic subthreshold anxiety during pregnancy influenced our decision (7).

Dr. Payne gives only limited consideration of psychological therapies, but these are equally effective and safer than medication, particularly in less severe depression (8). We recommended that psychological treatments should be offered without delay in order to avoid the risks associated with antidepressants where this is appropriate (2). The considerable