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