Presently, it is not known whether the association has causal relationships. In addition, our method does have some shortcomings (e.g., possibility of selection bias), although we utilized a fairly large sample size, with the finding being stable on different statistics. However, correlation of calcemia level with risperidone dose and literature data probably justifies additional research of possible causality. Risperidone, as well as other antipsychotics, can induce hyperprolactinemia and hypogonadism (2), synthesis of calcium binding proteins in the tissues (3), and changes in calcium-dependent signaling pathways (4), which could cause a calcium-depleted state and/or trigger calcium redistribution within body compartments. Individuals treated with antipsychotics have small but variable risks of hip fracture (5). With additional risks, even small disturbances of calcium homeostasis could make this population prone to osteoporosis and increase the probability of fractures.

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DRAGAN R. MILOVANOVIC, M.D., PH.D.
VLADIMIR JANJIC, M.D., M.SC.
NENAD ZORNIC, M.D., M.SC.
SLAVICA DJUKIC DEJANOVIC, M.D., PH.D.
SLOBODAN M. JANKOVIC, M.D., PH.D.
Kragujevac, Serbia

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Melancholia as a Distinct Mood Disorder? Recommendations for DSM-5

TO THE EDITOR: In an editorial in the July 2010 issue of the *Journal*, Gordon Parker, M.D. (1), and a distinguished group of 16 coauthors, including one of the Deputy Editors of this journal, made an argument for melancholia being classified as a distinct mood disorder. The arguments that 1) melancholia features a cluster of symptoms with greater consistency than the broad heterogeneity of the disorders and conditions included in major depression and bipolar disorder and 2) the melancholia diagnosis has superior predictability for prognosis and treatment were not well supported by the evidence. For example, the statement that melancholic patients rarely respond to placebos, psychotherapies, or social interventions could equally well apply to severe major depression and psychotic major depression, both of which are major depression subtypes, as is melancholia, allowed as "specifiers" in the DSM-IV classification of major depression. Relevant literature reveals that hypercortisolemia is not specific to the melancholia diagnosis (2, 3). More importantly, in many studies the melancholia diagnosis lacks predictive value for treatment selection, including response to antidepressant medications or differential predictive value for response across classes of antidepressants (4, 5). Because each of the specifiers designated in DSM-IV shares characteristics with the larger domain of major depression and yet each has its own distinctive qualities (for melancholia it is a characteristic cluster of symptoms), it makes sense to retain the current system in DSM-5.

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JAMES H. KOCSIS, M.D.
New York, N.Y.

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Reply to Kocsis Letter

TO THE EDITOR: Dr. Kocsis urges that DSM-5 should retain the status quo of melancholia as a specifier for major depressive disorder, whereas we recommended, based on much evidence (1, 2), that melancholia be positioned as a distinct mood disorder.