depression has been poor but it is (slowly) improving (DeBattista, 2006). Dr Vergouwen's suggestion that predictors of remission should be sought scientifically is most welcome. The studies mentioned are some of a number that look at the proportion of patients who respond late when early antidepressant response is disappointing (e.g. Mulsant *et al*, 2006). I am sure it will not be long before someone performs a meta-analysis yielding more-conclusive results. However, in clinical practice the alternative to continuing a drug which has generated a poor response is most commonly switching to another. However, from an evidence base standpoint this is where things get complex.

When considering analysis of benefit from a switch strategy after a certain number of weeks (say an 8-week *v*. 4-week switch with follow-up at 24 weeks), the methodology of an ideal trial is not straightforward and hence rare (to the point of invisibility!) in the literature. Three arms are required. Arm 1 includes patients who switch if non-responsive at 4 weeks; arm 2 those who switch if non-responsive at 8 weeks and, equally importantly, arm 3 patients who do not switch and stay on their original antidepressant for the duration of the trial. The third arm establishes how many would continue to enter remission even if initially non-responsive. Comparing switch with maximisation or augmentation or combination strategies would also ideally require a study of similar design. I know of no such studies, and the recruitment of the necessary number of patients with some level of treatment resistance is very difficult. A recent review of combination trials for treatment-resistant depression found only two that were randomised against a drug plus placebo arm (Dodd *et al*, 2005).

The other important issue is exactly how to separate responders from non-responders (or remitters from non-remitters) (Israel, 2006). In my view, because any definition of response is arbitrary, the threshold taken to define response (20%, 30% or 50% improvement, for example) will affect the success of the switch strategy. The main danger of switching too early is robbing a patient who was on a trajectory of good improvement from continuing successful treatment. The danger of switching too late is leaving a patient with distressing symptoms longer than necessary without effective treatment. In reality, ratings on a depression scale at 4 or 8 weeks after starting treatment will be somewhere between baseline and entirely asymptomatic – thus virtually all patients could be considered 'partial responders'. Many areas of psychopharmacology are moving towards early identification and treatment. I doubt that treatment-resistant depression will be the exception.

**DeBattista, C. (2006)** Augmentation and combination strategies for depression. *Journal of Psychopharmacology*, **20** (suppl.), 1–18.

**Dodd, S., Horgan, D., Malhi, G. S., *et al* (2005)** To combine or not to combine? A literature review of antidepressant combination therapy. *Journal of Affective Disorders*, **89**, 1–11.

**Israel, J. A. (2006)** Remission in depression: definition and initial treatment approaches. *Journal of Psychopharmacology*, **20** (suppl.), 5–10.

**Mulsant, B. H., Houck, P. R., Gildengers, A. G., *et al* (2006)** What is the optimal duration of a short-term antidepressant trial when treating geriatric depression? *Journal of Clinical Psychopharmacology*, **26**, 113–120.

**A. J. Mitchell** Department of Liaison Psychiatry, Brandon Unit, Leicester General Hospital, Leicester LE5 4PW, UK. Email: alex.mitchell@leicspart.nhs.uk
**doi: 10.1192/bjp.189.2.189b**

## Obsessive–compulsive disorder and central nervous system autoimmunity

Dale *et al* (2005) found high levels of anti-basal ganglia antibodies (ABGA) in the sera of children with obsessive–compulsive disorder (OCD) compared with control groups of children with streptococcal infection without OCD, paediatric autoimmune disease and neurological disorders (stroke, movement disorders and encephalitis) and concluded that central nervous system autoimmunity may play a role in a significant subgroup of children with OCD.

Recently, we found another auto-antibody, anti-phosphatidylethanolamine (aPE), which may have been associated with the sudden onset of OCD in a 5-year-old girl. Six weeks prior to showing symptoms of OCD, the girl was diagnosed with an ear infection, for which she received a full course of antibiotics. She presented at our clinic 2 months after the onset of OCD symptoms. Past medical history was significant for recurrent ear infection. Physical and neurological examinations were normal; no tics were observed. There was no family history of OCD.

At the index visit, the patient was negative for streptolysin O antibody. Throat cultures were negative for *Streptococcus pyogenes* and *Streptococcus* group A antigen. A test for deoxyribonuclease B, a marker for prior streptococcal infection, was negative.

To investigate an autoimmune diathesis, the patient was tested for IgG, IgA and aPE, anti-phosphatidylserine, anti-phosphatidylcholine and anti-cardiolipin antibodies (Sokol *et al*, 2000). Serial anti-phospholipid antibody testing revealed the persistence of IgG aPE antibodies; aPE antibody levels were coincident with the expression of OCD symptoms. The index and day 113 sera were also positive for IgG anti-phosphatidylserine antibodies. The patient was begun on a low dose of sertraline and her OCD improved.

We believe that this patient has a 'paediatric autoimmune neuropsychiatric disorder associated with streptococcal infection' (PANDAS-like condition) because the criteria, except for evidence of a group A streptococcal infection, were met. She had a history of repeated ear infections but her OCD symptoms occurred after the most recent infection. Without documenting the infectious agent, the elevated levels of aPE antibody suggest that she mounted an autoimmune reaction following another ear infection which led to the development of OCD.

We have found aPE antibodies in other neuropsychiatric conditions. An adolescent girl with a basal ganglia stroke had IgA aPE antibodies in her serum and IgG and IgA aPE antibodies in her cerebrospinal fluid; she experienced seizures and depression subsequent to the stroke (Sokol *et al*, 2000). Furthermore, aPE was the most frequently detected anti-phospholipid antibody in the serum of patients with psychosis (O'Brien *et al*, 2004). One-third of cerebrospinal fluid samples from this group contained IgG aPE antibody in the absence of this antibody in serum, suggesting intrathecal synthesis. We propose that aPE antibody may attack the basal ganglia, leading to its association with OCD and other disorders of the brain.

Although we report the finding of aPE antibodies with OCD in a single patient, we believe that aPE antibody should be considered as an additional autoimmune marker in post-infectious OCD.

**Dale, R. C., Heyman, I., Giovannoni, G., *et al* (2005)** Incidence of anti-brain antibodies in children with obsessive–compulsive disorder. *British Journal of Psychiatry*, **187**, 314–319.

**O'Brien, R. S., Sokol, D. K., Wagenknecht, D. R., *et al* (2004)** Antiphospholipid antibody (APL) in serum and CSF from patients with psychosis. *Thrombosis Research*, **114**, 629.

**Sokol, D. K., McIntyre, J. A., Short, R. A., *et al* (2000)** Henoch–Schönlein purpura and stroke: antiphosphatidylethanolamine antibody in CSF and serum. *Neurology*, **55**, 1379–1381.

**D. K. Sokol** Indiana University School of Medicine, 575 West Drive, Indianapolis, IN 46202, USA. Email: dksokol@iupui.edu
**L. M. McGuire, N. S. Johnson, D. R. Wagenknecht, J. A. McIntyre** St Francis Hospital and Health Centers, Indianapolis, USA
**doi: 10.1192/bjp.189.2.190**

### Ethyl-eicosapentaenoic acid in bipolar depression

Frangou *et al* (2006) reported ethyl-eicosapentaenoic acid (ethyl-EPA) to be effective in the treatment of bipolar depression. However, no mention is made of the dietary intake of ethyl-EPA among the randomised groups. Ethyl-EPA is a naturally occurring substance and hence a potential confounding variable. The statistically significant improvements in the ethyl-EPA group(s) compared with placebo in terms of decreases in scores on the Hamilton Rating Scale for Depression and the Clinical Global Impression Scale could simply have been a result of differences in dietary ethyl-EPA intake. Such a difference is likely to have involved increased intake in the ethyl-EPA group(s), but decreased intake in these groups could have lessened any potential improvements. Further studies of omega-3 fatty acids must control for the potential confounding independent variable of dietary intake.

**Frangou, S., Lewis, M. & McCrone, P. (2006)** Efficacy of ethyl-eicosapentaenoic acid in bipolar depression: randomised double-blind placebo-controlled study. *British Journal of Psychiatry*, **188**, 46–50.

**I. Upton** Ashworth Hospital, Parkbourn, Liverpool L31 1HW, UK.
Email: ianupton84@yahoo.co.uk
**doi: 10.1192/bjp.189.2.191**

# One hundred years ago

### News and notes

Dr. RAYNER: The Editors beg to report that there has been no material change in the production of the Journal during the year 1905.

The number of copies printed remains 1075, although from the steadily increasing membership the number will probably require to be increased at the end of the present year, as well as from a slight increase in the sale of the Journal of the Association.

The cost of the production of the Journal remains practically the same as during the past ten years, although the numbers printed have increased so considerably. In the present year, on the advice of the publishers, the net sale price has been increased slightly, and this on the present sale of the Journal will increase the receipts from this source by some £25.

The advertisements also show a tendency to increase, although still very much below the amount that might be reasonably expected when the importance of the opportunity of advertising is considered. The fact that the Journal is regularly in the hands of the medical officers of hospitals containing more than 100,000 beds should attract the attention of all concerned in the supply of hospital requisites. The members of the Association individually might greatly aid in making the value of the Journal, from an advertisement point of view, better known to possible advertisers.

The Editors wish again to express their thanks to their sub-editor, Dr. Lord, for the very valuable and important assistance that he has given during the past year

HENRY RAYNER.
A. R. URQUHART.
CONOLLY NORMAN.
JAMES CHAMBERS.

Dr. CONNOLLY NORMAN seconded the report, and it was carried.

#### REFERENCE

*Journal of Mental Science*, October 1906, 813.

**doi: 10.1192/bjp.189.2.191a**

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

# Corrigendum

Generalisability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial. *BJP*, **189**, 65–73. The percentage for 'Any competitive job over 12 months' in the 'Usual service' group in Table 2b (p. 71) should be 17.6. The doi for this paper is 10.1192/bjp.bp.105.012641; the doi included with the online version has been corrected in deviation from print and in accordance with this corrigendum.