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Author's reply: Dr Daly argues that the link between child sexual abuse and adult psychosis may be the result of confounding by psychotic symptoms in childhood or adolescence. He adduces evidence for this from his secondary analysis of data from the 1970 British Birth Cohort sample.[1] Of the female sample, 1.6% indicated that they had been forced to have sex by the age of 16, and this was associated with an elevated risk of visual and auditory hallucinations at age 29 (OR = 8.5). However, after controlling for the experience of such quasi-psychotic symptoms before the age of 16, the odds ratio fell to a non-significant 2.4. Daly interprets this as indicating that this relationship exists because children with quasi-psychotic symptoms are more at risk of abuse and also at greater risk of developing psychosis as adults.

Nevertheless, Dr Daly's conclusion must equally be tentative. First, the British Birth Cohort sample apparently does not provide temporal discrimination between the occurrence of sexual abuse and the development of quasi-psychotic symptoms. Second, given that this is so, the diminution of the odds ratio after controlling for quasi-psychotic symptoms in adolescence could indicate mediation. In other words, the sexual abuse leads to adolescent symptoms which are then associated with adult symptoms. I find this explanation more plausible than the suggestion that psychotic symptoms themselves have a major effect in increasing vulnerability to abuse. There is some evidence that psychotic symptoms in adolescence are associated with prior abuse.[2]

It would be good to resolve this argument with appropriate data from a cohort study. However, this might not be possible: there are considerable ethical difficulties in contemporaneous enquiry about sexual abuse in child and adolescent epidemiological samples. Current research has provided some indication that the psychological consequences of abuse show similarities to psychological antecedent and maintaining factors in psychosis,[3,4] and this does add plausibility to the aetiological role of sexual abuse. The particular association of early trauma with psychotic disorders (schizophreniform or bipolar) characterised by hallucinations is also difficult to explain in terms of confounding.[5,6]

The final worry about Dr Daly's argument is that it may detract attention from therapeutic engagement with the consequences of sexual abuse and other trauma in people with psychosis.

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Revascularisation in patients with mental illness

Mitchell *et al* must be congratulated on their systematic review of myocardial revascularisation in patients with mental illness.[1] As physicians performing revascularisation procedures, we were disappointed by the inferior treatment received by patients with mental health problems. Fortunately, these patients account for only a minority of those presenting to acute cardiology services with symptoms and signs suggestive of acute coronary syndrome. However, when they do attend, they present cardiologists with a number of challenges, which ultimately can influence the decision regarding treatment.

Revascularisation remains an important treatment for those patients with myocardial necrosis, providing both symptomatic and prognostic benefit.[2] Importantly, however, it can only be performed following invasive coronary angiography – a procedure which carries a risk of vascular complication, myocardial infarction, stroke or even death of 0.2–1.0%. Clearly, patients must give appropriate consent before coronary angiography is undertaken, and this can represent an important hurdle when treating patients with mental health problems.

A second important challenge which should be considered prior to undertaking angiography, and must be considered prior to performing definitive revascularisation, is the issue of adherence to medication. Frequently, revascularisation can be performed percutaneously at the time of angiography. This procedure usually necessitates the implanting of coronary stents, which are small permanent metal scaffolds that help maintain coronary vessel patency. There are many advantages to using these devices; however, in recent times stent thrombosis has emerged as the most serious and worrying complication of their use.[3] This condition is fortunately rare, but it remains a devastating, unpredictable event that has a significant morbidity and mortality; up to a third of patients will die. Research has identified that early or premature discontinuation of dual antiplatelet therapy is one of the most important risk factors in stent thrombosis.[4] Consequently, cardiologists are reluctant to implant stents in patients who they feel are unlikely to comply with dual antiplatelet therapy. Unfortunately, patients with mental illness have been shown to be less adherent to medication,[5] a factor which certainly has as an influence on revascularisation decisions.

These issues represent important challenges (and not excuses), which must be overcome to allow our patients to receive the most appropriate treatment. The differences in treatment certainly deserve to be highlighted and as recommended by Mitchell *et al* the reasons behind them require more in depth investigation, especially within the confines of the National Health Service.

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