Child psychiatry liaison services

SIR: McFadyen *et al*'s descriptive account of the impact of a child psychiatry liaison service on patterns of referral (*Journal*, January 1991, **158**, 93–96) provides a timely impetus to this rapidly expanding area of child psychiatry.

While it is clear that the reorganisation of child psychiatric services resulted in a considerable increase in the number of liaison referrals, it may be useful to point out that there are other spin-offs from the provision of such services in paediatric units.

Our experience in Coventry suggests that senior registrar trainees in paediatrics, who are exposed to liaison services, incorporate some of the principles involved in those services and, subsequently, on obtaining consultant posts tend to value the contribution which child psychiatry can make to management of the psychological aspects of physical illness. This is in addition to helping to raise the awareness of nursing and other staff. We have noted that in the past six months the number of non self-harm referrals to the department of child psychiatry has virtually doubled since the appointment of a consultant paediatrician who has had training which was strongly informed by child psychiatry liaison services. This strengthening in the link with paediatrics, which we are currently monitoring prospectively, increases opportunities for involvement at many different levels beneficial to patient care.

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Beyond pumpkin seeds

SIR: We are interested in Eagles' letter (*Journal*, December 1990, **157**, 937–938) regarding the use of pumpkin seeds as a source of L-tryptophan, but suggest that there may be an alternative way of tackling the problem.

Since the withdrawal of L-tryptophan, a considerable number of patients previously receiving it have relapsed. In our experience, the time lapse involved has been between two weeks and two months after discontinuation. An answer to this seemed to be the reinstitution of L-tryptophan in a number of people on a named-patient basis. To this end we have generated a 'tryptophan monitoring clinic'. This is run with a multi-disciplinary team of doctor, nurse and hospital pharmacist. Supplies of L-tryptophan in the form of Optimax are available through the hospital pharmacy, via a signed request from the consultant in charge of each case.

The eight patients involved so far are all over sixty-five years old and have a long history of treatment-resistant depression. The majority are receiving lithium carbonate and a tricyclic antidepressant at therapeutic dosage with L-tryptophan as the third part of a triple therapy.

The clinic is held at the Day Hospital. Patients are seen for mental state examination, plus discussion of any risks and problems, by the doctor. There is also an opportunity for discussion with the nurse who takes blood samples to measure eosinophil counts. Monitoring of blood follows Committee on Safety of Medicines (CSM) recommendations and advice from the drug company. The pharmacist gives each patient personal information sheets relating to L-tryptophan and any of its potential side-effects. She dispenses sufficient supplies of L-tryptophan to last until the next clinic appointment (maximum one month). General Practitioners are informed that the patients are receiving L-tryptophan from hospital.

To date, improvement of mood is noticeable in all but one patient. In one hundred and forty-two patient weeks, four eosinophil counts have been very marginally above the normal laboratory range ($0.04–0.4 \times 10^9$/l). These have all reverted to within normal range at early re-test. No patients have shown any physical symptoms of eosinophilia myalgia syndrome.

We envisage continuing this service as long as the need persists. We have also started to see out-patients who are commencing L-tryptophan for the first time and for whom the consultant in charge feels this is the next step in their treatment programme.

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Blinding trials

SIR: I think the dispute between Newcombe (*Journal*, December 1990, **157**, 934–935) and myself (*Journal*, August 1990, **157**, 300) about the value of double-blind trials arises partly because of his idealistic view of the randomised controlled trial. The logic of the method is essentially unassailable, but I am more concerned with the real world of clinical practice. The problem of unblinding will not be solved merely by pleas for improved study design and execution.

Dr Newcombe's useful critique of the study by Karlowski *et al* (1975) fails to reach a practical conclusion about whether ascorbic acid is effective in the treatment of a common cold. Should we, therefore, take the advice of the Nobel Prize winner, Linus