

EDITOR'S NOTE

This column reflects our commitment to provide you, the primary care physician, with information that will prove helpful in making informed decisions about the care of your patients who suffer from psychiatric disorders. We will highlight abstracts of high interest to you from our sister publication, *The Journal of Clinical Psychiatry*, and summarize pertinent articles from the general scientific literature. We hope that this section is clinically relevant to your practice and that it will encourage you to expand your horizons.

Group Interpersonal Psychotherapy for Depression in Rural Uganda

Bolton P, Bass J, Neugebauer R, et al.

Context: Despite the importance, few controlled intervention trials related to mental illness in Africa have been published. **Objectives:** To evaluate the feasibility of conducting controlled trials in Africa and to test the efficacy of group interpersonal psychotherapy in alleviating depression and dysfunction. **Design, Setting, and Participants:** Thirty villages in the Masaka and Rakai districts of rural Uganda were selected using a random procedure for this cluster randomized, controlled clinical trial (February–June 2002). Fifteen villages were then randomly assigned for studying men and 15 for women. Adult men and women in each village believed by themselves and other villagers to have depressionlike illness were interviewed using an instrument assessing function and a locally adapted Hopkins Symptom Checklist. Lists were created based on these interviews for each village totaling 341 men and women who met DSM-IV criteria for subsyndromal depression or major depression. Interviewers revisited them in order of decreasing symptom severity until they had 8 to 12 persons per village for a total of 284. Of these, 248 agreed to be in the trial and 9 refused; the remainder died or relocated. A total of 116 women and 108 men completed the study and were reinterviewed. **Intervention:** Seven of the 15 female villages and 8 of the 15 male villages were randomly assigned to the intervention arm; the remaining villages were assigned to the control arm. Interpersonal psychotherapy for depression was provided for the intervention villages as weekly 90-minute sessions for 16 weeks. **Main Outcome Measures:** Proportion of persons meeting DSM-IV major depression diagnostic criteria, and depression and dysfunction severity scores on scales adapted and validated for local use. **Results:** Mean reduction in depression severity was 3.55 points for controls and 17.47 points for intervention groups ($p < .001$). Mean reduction in dysfunction was 8.08 and 3.76 points, respectively ($p < .001$). Of the intervention and control groups, 6.5% and 54.7%, respectively, met the criteria for major depression after intervention compared with 86% and 94%, respectively, prior to intervention ($p = .04$). The odds of postintervention depression among controls was 17.31 (95% CI = 7.63 to 39.27) compared with the odds among intervention groups. Intention-to-treat analysis results remained statistically significant. **Conclusions:** Group interpersonal psychotherapy was very effective in reducing dysfunction and depression, and a clinical trial proved feasible in the local setting. Similar trials should be encouraged in analogous settings in Africa and elsewhere in light of both findings.

(*JAMA* 2003;289:3117–3124)

A Double-Blind Comparison of Olanzapine Versus Risperidone in the Acute Treatment of Dementia-Related Behavioral Disturbances in Extended Care Facilities

Fontaine CS, Hynan LS, Koch K, et al.

Background: In addition to demonstrating their superiority to placebo, there is a need to compare the relative efficacy and side effects of atypical neuroleptics for the acute treatment of dementia-related behavioral disturbances in residents of long-term care facilities. **Method:** In a double-blind parallel study allowing dose titration over 14 days, 39 agitated persons with DSM-IV dementia who were residing in long-term care facilities were administered olanzapine ($N = 20$) or risperidone ($N = 19$) as acute treatment. Drug was administered once a day at bedtime. The initial dosages were olanzapine, 2.5 mg/day, and risperidone, 0.5 mg/day. Titration was allowed to maximum doses of olanzapine, 10 mg/day, and risperidone, 2.0 mg/day. The primary outcome measures were the Clinical Global Impressions scale (CGI) and the Neuropsychiatric Inventory (NPI). Data were gathered from 2000 to 2002. **Results:** Both drugs produced significant reductions in CGI and NPI scores ($p < .0001$), but there was no significant difference between drugs. The mean olanzapine dose was 6.65 mg/day; for risperidone, the dose was 1.47 mg/day. The positive drug effect was not accompanied by decreased mobility, and there was improvement on a quality-of-life measure. The chief adverse events were drowsiness and falls. At baseline, 42% (16/38) of

subjects in both groups had extrapyramidal symptoms that increased slightly, but not significantly, by the end of the study. **Conclusion:** Low-dose, once-a-day olanzapine and risperidone appear to be equally safe and equally effective in the treatment of dementia-related behavioral disturbances in residents of extended care facilities.

(*J Clin Psychiatry* 2003;64:726–730)

Suicide Following Deliberate Self-Harm: Long-Term Follow-Up of Patients Who Presented to a General Hospital

Hawton K, Zahl D, Weatherall R

Background: The strongest risk factor for future suicide is deliberate self-harm (DSH). There is a lack of up-to-date information on the extent of risk. **Aims:** To investigate, after a long follow-up period, the risk of suicide after DSH. **Method:** Patients (N = 11,583) who presented to hospital after DSH between 1978 and 1997 were included in a mortality follow-up study to 2000. Data collection was completed from the general hospital DSH register in Oxford, the Office for National Statistics, and equivalent mortality registers in Northern Ireland and Scotland. **Results:** Of those patients followed, 300 had died by suicide or probable suicide. The risk in the first year of follow-up was 0.7% (95% CI = 0.6 to 0.9%), and this was 66 (95% CI = 52 to 82) times the risk of suicide in the general population annually. After 5 years, the risk was 1.7%, at 10 years 2.4%, and at 15 years 3.0%. In men, the risk was far higher than in women (hazard ratio = 2.8, 95% CI = 2.2 to 3.6). It increased markedly in both genders with age at initial presentation. **Conclusions:** There is a persistent and significant risk of suicide following DSH that varies between age groups and genders. National suicide prevention strategies must include reduction in the risk of suicide following DSH as a key element.

(*Br J Psychiatry* 2003;182:537–542)

Depression and Other Psychological Risks Following Myocardial Infarction

Frasure-Smith N, Lespérance F

Background: Depression symptoms predict long-term mortality following a myocardial infarction according to consistent evidence. Recent results indicate a dose-related gradient. It remains unclear as to the importance of other psychological variables. **Methods:** The relative importance of depression, anxiety, anger, and social support in predicting 5-year cardiac-related mortality following a myocardial infarction is examined in this study, and the role of any common underlying dimensions is assessed. This cohort analytic study design included the following self-reports: Beck Depression Inventory, 20-item version of the General Health Questionnaire, Modified Somatic Perception Questionnaire, Perceived Social Support Scale, state scale of the State-Trait Anxiety Inventory, Anger Expression Scale, visual analog scales of anger and stress, and number of close friends and relatives. The study was conducted in 10 Montreal-area hospitals and included 896 patients who experienced a myocardial infarction, aged 24 to 88 years (232 women). Patients were followed up for 5 years using Medicare records, and there were complete baseline data for 95% of the patients. The main outcome measure was 5-year cardiac-related mortality, and the intervention was usual care. **Results:** Only depression

remained significant after adjustment for cardiac disease severity (hazards ratio per SD = 1.46, 95% CI = 1.18 to 1.79) ($p < .001$). Outcome was related to the 20-item version of the General Health Questionnaire ($p = .048$), the State-Trait Anxiety Inventory ($p = .04$), and the Beck Depression Inventory ($p < .001$). Three underlying factors were revealed through exploratory factor analysis: social support, overt anger, and negative affectivity. There was a covariate-adjusted trend between outcome and negative affectivity scores ($p = .08$). Negative affectivity scores ($p = .05$) and residual depression scores ($p = .001$) were linked to cardiac-related mortality after adjustment for cardiac covariates and each other. **Conclusions:** Negative affectivity and some unique aspect of depression predict long-term cardiac-related mortality following a myocardial infarction independently of cardiac disease severity and each other. In order to characterize the mechanisms involved, additional research is needed.

(*Arch Gen Psychiatry* 2003;60:627–636)

How Common Is Obsessive-Compulsive Disorder in a Dermatology Outpatient Clinic?

Fineberg NA, O'Doherty C, Rajagopal S, et al.

Background: This study was prompted by reports suggesting a high prevalence of unrecognized obsessive-compulsive disorder (OCD) in the dermatology clinic. **Method:** 92 consecutive dermatology referrals were screened for DSM-IV OCD using the Mini-International Neuropsychiatric Interview (MINI), the Yale-Brown Obsessive Compulsive Scale (YBOCS), and the 5-item screening questionnaire from the International Council on OCD. Illness severity was rated on the YBOCS, and symptom profiles and dermatologic diagnoses were established for screen-positive cases. **Results:** 18 patients (20%) qualified for a DSM-IV diagnosis of OCD, of whom 17 were previously undiagnosed. The range and type of OCD symptoms covered the normal clinical spectrum. Most patients had more than 1 symptom, and among obsessions (including somatic obsessions), checking, washing, and symmetry were common. The mean total YBOCS score was 16/40 (SD = 7.2), indicating moderate OCD, and 40% of the positive cases scored 16 or higher. Dermatologic diagnoses were various and did not seem to bear a direct relationship with the OCD. **Conclusion:** These results suggest that there is a high prevalence of clinically relevant OCD in the dermatology clinic. This is an area that merits attention with regard to better recognition and treatment for OCD sufferers.

(*J Clin Psychiatry* 2003;64:152–155)

The Epidemiology of Major Depressive Disorder: Results From the National Comorbidity Survey Replication (NCS-R)

Kessler RC, Berglund P, Demler O, et al.

Context: There is uncertainty regarding prevalence and correlates of major depressive disorder (MDD). **Objective:** To present nationally representative data on prevalence and correlates of MDD using DSM-IV criteria, as well as on correlates of treatment and treatment adequacy and study patterns using the National Comorbidity Survey Replication (NCS-R). **Design:** Household face-to-face survey conducted during the period of February 2001 to December 2002. **Setting:** The 48 contiguous

United States. **Participants:** Residents in households who responded to the NCS-R survey aged 18 years or older (N = 9090). **Main Outcome Measures:** Prevalence and correlates of MDD using the World Health Organization's (WHO) Disability Assessment Scale (WHO-DAS), the WHO Composite International Diagnostic Interview (CIDI), the Sheehan Disability Scale (SDS), and 12-month severity with the Quick Inventory of Depressive Symptomatology Self-Report (QIDS-SR). The Structured Clinical Interview for DSM-IV was used for clinical reinterviews. **Results:** Lifetime prevalence of CIDI MDD was 16.2% (95% CI = 15.1 to 17.3) (32.6–35.1 million U.S. adults) and for 12 months was 6.6% (95% CI = 5.9 to 7.3) (13.1–14.2 million U.S. adults). Of the 12-month cases, almost all were classified independently as clinically significant using the QIDS-SR, with 10.4% mild, 38.6% moderate, 38.0% severe, and 12.9% very severe. Mean episode duration was 16 weeks (95% CI = 15.1 to 17.3). As measured by SDS, role impairment was substantial as indicated by 59.3% of 12-month cases with severe or very severe role impairment. Most 12-month (78.5%) and lifetime (72.1%) cases had comorbid CIDI/DSM-IV disorders, and MDD was rarely primary. Treatment was adequate in only 41.9% (95% CI = 35.9 to 47.9) of these cases, although 51.6% (95% CI = 46.1 to 57.2) of 12-month cases received health care treatment for MDD, resulting in 21.7% (95% CI = 18.1 to 25.2) of 12-month MDD being adequately treated. Sociodemographic treatment correlates were far less numerous than prevalence correlates. **Conclusions:** Major depressive disorder is common, widely distributed, and usually associated with substantial role impairment and symptom severity. Although a recent increase in treatment is encouraging, inadequate treatment is a serious concern. Screening emphasis and treatment needs expansion must be accompanied by an emphasis on treatment quality improvement. (*JAMA* 2003;289:3095–3105)

Psychiatric Symptoms in Patients With Chronic Hepatitis C Receiving Interferon Alfa-2b Therapy

Kraus MR, Schäfer A, Faller H, et al.

Background: Psychiatric side effects of interferon alfa are frequently observed in the therapy of patients with chronic hepatitis C infection. The goal of the present study was to assess prospectively the incidence, spectrum, and extent of psychiatric symptoms of patients receiving interferon alfa therapy as compared with an untreated reference group. **Method:** 104 patients with chronic hepatitis C were consecutively enrolled in a prospective longitudinal study. The treatment group (N = 84) received interferon alfa-2b for up to 12 months, and the reference group (N = 20) received no treatment. Patients who began treatment between November 1996 and August 1998 (N = 44) received interferon alfa-2b, 5 million units 3 times per week. Patients who began treatment in September 1998 or later (N = 40) received a combination of interferon alfa-2b, 3 to 5 million units 3 times per week, and ribavirin, 1000–1200 mg/day. Diagnostic scores for depression and anxiety were obtained by means of the psychometric instrument Hospital Anxiety and Depression Scale, and scores for anger/hostility were obtained with the Symptom Checklist-90 Revised. **Results:** In contrast to the untreated reference group, we found significantly increased scores for depression ($p < .001$) and anger/hostility ($p < .001$) during interferon alfa therapy in the treatment group. Even before therapy, scores of those in the treatment group were above the respective cutoff values for clinically relevant symp-

ptoms of depression in 15.5% of the patients, anxiety in 13.1% of the patients, and anger/hostility in 11.3% of the patients. These proportions rose to 35.0% (depression), 25.6% (anxiety), and 24.5% (anger/hostility). The cumulative frequency of clinically relevant emotional distress (depression, anxiety, or anger/hostility) during interferon alfa therapy was 57.7%, as compared with 22.5% before therapy. However, interferon alfa therapy had to be stopped prematurely because of untreatable psychiatric symptoms in only 8.3% of patients. **Conclusion:** In view of the high frequency and extent of psychiatric symptoms with interferon alfa therapy, we recommend a close follow-up of patients receiving this therapy with respect to potential limiting mood changes.

(*J Clin Psychiatry* 2003;64:708–714)

Use of Atypical Antipsychotic Drugs in Patients With Dementia

Motsinger CD, Perron GA, Lacy TJ

Atypical antipsychotic drugs are often prescribed for elderly patients with behavioral disturbances and symptoms of psychosis. Patients with Alzheimer's disease, Parkinson's disease, or other dementias often exhibit these symptoms. The prevalence of Alzheimer's disease and Parkinson's disease will rise as the average age of Americans increases. Medications are often needed to enable the patient to be adequately cared for, although nonpharmacologic treatments for behavioral disturbances should be tried initially. According to current guidelines, risperidone and olanzapine are recommended treatments for psychosis in patients with Alzheimer's dementia. Clozapine and quetiapine are recommended treatments for psychosis in Parkinson's disease patients. Additional research is needed for ziprasidone, a recently approved agent. The medications should be started at low doses to minimize side effects, and drug interactions, especially those involving the cytochrome P450 system, must be considered. Clozapine's use is limited in the primary care setting due to its potentially lethal side effects. Family physicians may greatly improve the quality of life in elderly patients with dementia and behavior disturbances through informed use of atypical antipsychotic drugs.

(*Am Fam Physician* 2003;67:2335–2340)

Safety of Available Agents Used to Treat Bipolar Disorder: Focus on Weight Gain

Nemeroff CB

Background: Pharmacotherapeutic management of bipolar disorder has advanced considerably since the introduction of lithium therapy nearly 50 years ago. The sizable percentage of patients who do not respond adequately to lithium and/or are intolerant to its side effects has served as an impetus for identifying alternative pharmacotherapeutic agents. Recent advances in the understanding of the neurotransmitter systems and their receptors as it applies to treatment of bipolar disorder has, in part, led to progress in delineating applications of anticonvulsant/antiepileptic drugs (AEDs) in this area. Although the efficacy of many drugs has been evaluated in patients with this disorder, medication tolerability and adherence issues related to unfavorable side effect profiles are substantial impediments to the development of novel pharmacotherapies. The potential for excessive weight gain as a side effect of

certain psychopharmacologic agents remains a concern to both clinicians and patients. **Method:** English-language literature from 1985–2001 in MEDLINE was searched for the terms *bipolar disorder*, *anticonvulsant*, *antiepileptic*, *lithium*, *antipsychotic*, *weight*, and *compliance*. This article reviewed current therapeutic options for bipolar disorder, including newer AEDs and atypical antipsychotic drugs, with emphasis on the issue of weight gain and possible approaches to minimizing this risk. **Results:** Certain newer AEDs are characterized by more favorable safety and tolerability profiles that include weight loss as a desirable side effect. Because bipolar disorder is associated with unacceptably high rates of relapse, recurrence, and morbidity, the concept of pharmacotherapeutic efficacy logically not only includes symptom relief but also necessarily encompasses issues related to regimen tolerability and adherence. **Conclusion:** There is a need for guidelines to help physicians carefully formulate and individualize management plans to reach safe, effective, and cost-efficient patient outcomes. Monitoring the weight of patients with bipolar disorder and educating them regarding this issue should be standard components of any treatment plan.

(*J Clin Psychiatry* 2003;64:532–539)

Cost of Lost Productivity Work Time Among U.S. Workers With Depression

Stewart WF, Ricci JA, Chee E, et al.

Context: Consistent evidence indicates that work productivity is adversely affected by depression. Cost impact estimates of lost labor time in the U.S. workforce are dated and scarce. **Objective:** To estimate in the U.S. workforce the impact of depression on labor costs (i.e., reduced performance at work and absences). **Design, Setting, and Participants:** Employed individuals who participated in the American Productivity Audit (conducted August 1, 2001 to July 31, 2002) between May 20, 2002, and July 11, 2002 were eligible for the Depressive Disorders Study. Recruits consisted of those who responded affirmatively to 2 depression-screening questions (N = 692), as well as a 1:4 stratified random sample of those responding negatively (N = 435). Those selected completed a supplemental interview using the Somatic Symptom Inventory, the Primary Care Evaluation of Mental Disorders Mood Module for depression, and a medical treatment history for depression. Excess lost productive time (LPT) costs as a result of depression were derived as the difference in LPT among individuals with depression minus the expected LPT in the absence of depression projected to the U.S. workforce. **Main Outcome Measure:** Estimated LPT and associated labor costs (reduced performance while at work and absences) as a result of depression. **Results:** Depressed workers reported significantly more total health-related LPT than those without depression (mean, 5.6 h/wk vs. an expected 1.5 h/wk, respectively). Reduced performance at work explains 81% of the LPT costs. Forty-eight percent of the LPT among those with depression is due to major depression; a majority of the cost is explained by reduced performance at work. There was low self-report of use of antidepressants in the past 12 months among depressed individuals (< 30%); the mean reported treatment effectiveness was only moderate. Extrapolation of self-reported annual incomes and these survey results to the population of U.S. workers suggest that U.S. workers with depression employed in the previous week cost employers an estimated \$44 billion per year in LPT, an excess of \$31 billion per year compared with nondepressed peers. Labor costs associated with

short- and long-term disability are not included in this estimate. **Conclusions:** Reduced performance at work explains a majority of the LPT costs that employers face from invisible employee depression. Depression treatment use appears to be relatively low. The combined LPT burden among depressed individuals and the low level of treatment suggests that there may be cost-effective opportunities for improving depression-related outcomes in the U.S. workforce.

(*JAMA* 2003;289:3135–3144)

Controlled Clinical Trial of Interpersonal Psychotherapy Versus Parenting Education Program for Depressed Pregnant Women

Spinelli MG, Endicott J

Objective: Antenatal depression, which is present in 10% to 12% of all pregnancies, is associated with significant risk for postpartum depression. Pregnant women with chronic stressors, financial and housing problems, and inadequate social support have higher rates of depression. However, no controlled treatment trials employing interpersonal psychotherapy have been conducted studying antepartum depression, a prevalent condition that is associated with family and infant mortality whose treatment has been identified by the American Psychiatric Association as a priority for clinical guidelines. **Method:** In this 16-week bilingual controlled trial, women receiving interpersonal psychotherapy for antepartum depression were compared with depressed pregnant women in a parenting education control group. A total of 50 outpatient antepartum women meeting DSM-IV criteria for major depressive disorder were randomly assigned to 1 of the 2 groups; the 38 women who remained in the study were included in the data analysis. The Edinburgh Postnatal Depression Scale, the Beck Depression Inventory, and the Hamilton Rating Scale for Depression (HAM-D) were used to measure depression, and the Clinical Global Impression (CGI) and the HAM-D were used to measure recovery. **Results:** Compared with the parenting education control group, the interpersonal psychotherapy treatment group showed significant improvement on all 3 measures of mood at termination. Recovery, defined as a CGI score ≤ 2 , was achieved by 60% of the women in the treatment group. Furthermore, a significant correlation was found between maternal mood and mother-infant interaction. **Conclusions:** Interpersonal psychotherapy is effective as antidepressant treatment during pregnancy and is deserving of first-line status in the treatment armamentarium for antepartum depression.

(*Am J Psychiatry* 2003;160:555–562)

Factors at Play in Faster Progression for Female Pathological Gamblers: An Exploratory Analysis

Tavares H, Martins SS, Lobo DSS, et al.

Background: Previous studies reported a faster progression for alcohol dependence and pathological gambling among females as compared with males. This phenomenon was called the “telescoping effect.” By comparing female gamblers with male gamblers regarding gambling preferences and comorbidity, the authors explored potential risk factors for telescoping. **Method:** A consecutive sample of Brazilian treatment-seeking pathological gamblers (DSM-IV criteria) was recruited. Genders were

contrasted regarding comorbidity and gambling behavior, controlling for demographics, gambling severity, and previous access to mental health services. **Results:** Seventy female gamblers and 70 male gamblers were interviewed. A greater proportion of women than men reported electronic bingo and video lottery terminals as their main type of gambling. Gambling was divided in 3 progressive stages: "social gambling," "intense gambling," and "problem gambling." Faster progression for female gamblers was confirmed; female gender and preference for electronic bingo and/or video lottery terminals were risk factors for telescoping throughout all stages. Female gamblers presented a higher comorbidity with depression, whereas male gamblers had higher rates of alcohol dependence. Nevertheless, comorbidity profiles were not related to gambling progression. **Conclusion:** Two factors could be at play for treatment-seeking female gamblers in Brazil: (1) a potential gender vulnerability and (2) a cultural environment yielding them access to a narrower range of gambling games that includes mainly the most addictive ones.

(*J Clin Psychiatry* 2003;64:433-438)

Leisure Activities and the Risk of Dementia in the Elderly

Verghese J, Lipton RB, Katz MJ, et al.

Background: A lower risk of dementia has been associated with participation in leisure activities. It is not clear if participation in leisure activities declines during the preclinical phase of dementia or whether increased participation in leisure activities lowers the risk of dementia. **Methods:** The relation between the risk of dementia and leisure activities was examined in a prospective cohort of 469 subjects older than 75 years of age who lived in the community and did not have dementia at baseline. The frequency of participation in leisure activities at enrollment was examined and cognitive-activity and physical-activity scales derived in which the units of measure were activity-days per week. Dementia risk was evaluated according to the baseline level of participation in leisure activities, with adjustment for age, sex, education, baseline cognitive status, and absence or presence of chronic medical illness using the Cox proportional-hazards analysis. **Results:** Dementia developed in 124 subjects over a median follow-up period of 5.1 years (Alzheimer's disease in 61 subjects, vascular dementia in 30, mixed dementia in 25, and other types of dementia in 8). Reading, playing board games, playing musical instruments, and dancing were associated with reduced dementia risk. A reduced dementia risk was

associated with a 1-point increment in the cognitive-activity scores (hazard ratio = 0.93, 95% CI = 0.90 to 0.97), but a 1-point increment in the physical-activity score was not (hazard ratio = 1.00). After the exclusion of the subjects with possible preclinical dementia at baseline, the association with the cognitive-activity score persisted. Results were similar for vascular dementia and Alzheimer's disease. In linear mixed models, reduced rates of decline in memory were associated with increased participation in cognitive activities at baseline. **Conclusions:** Leisure activity participation is associated with a reduced dementia risk, even after the exclusion of subjects with possible preclinical dementia and after adjustment for baseline cognitive status. Controlled trials are necessary to assess the protective effect of cognitive leisure activities on dementia risk. (*N Engl J Med* 2003;348:2508-2516)

A Review of the Safety and Efficacy of Droperidol for the Rapid Sedation of Severely Agitated and Violent Patients

Shale JH, Shale CM, Mastin WD

Background: Droperidol had become a standard treatment for sedating severely agitated or violent patients in both psychiatric and medical emergency departments. However, several recent articles have suggested that droperidol may have a quinidine-like effect similar to that of thioridazine in inducing dysrhythmia. **Method:** In view of the recent U.S. Food and Drug Administration (FDA) position regarding the use of thioridazine, the authors reviewed the literature regarding droperidol and dysrhythmia in a MEDLINE search for the years 1960-2002 using the search terms *droperidol*, *dysrhythmia*, *QTc interval*, and *sudden death* as well as their own experience in using droperidol in a busy psychiatric emergency department. This review was done before the FDA's very recent and preemptory warning about droperidol. **Results:** The authors report that, in treating approximately 12,000 patients over the past decade, they have never experienced a clinically significant adverse dysrhythmic event using droperidol to sedate severely agitated or violent patients. **Conclusion:** The authors conclude that, in clinical practice, droperidol is an extremely effective and safe method for treating severely agitated or violent patients. While in theory droperidol may prolong the QT interval to an extent similar to thioridazine, in clinical use there is no pattern of sudden deaths analogous to those that provoked the FDA warning about thioridazine.

(*J Clin Psychiatry* 2003;64:500-505)