We therefore strongly agree with Dr Kay's recommendation that the value of the simple measure of the administration of 150 mg aspirin should not be overlooked in the management of all patients presenting to their general practitioner with acute cardiac chest pain.

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Which antidepressant?

Sir,

I was interested to read the article on antidepressants by Matthews and Eagles (March *Journal,* p.123). The criteria for choosing an antidepressant — efficacy, adverse effects, toxicity in overdose and cost — could have included another, experience with the drug.

Amitriptyline may have irritating adverse effects but it has been around for a long time. It can be prescribed with confidence, in the knowledge that its efficacy is undoubted and that new adverse effects are unlikely to be discovered. The same cannot be said of some of the newer drugs. Sertraline (Lustral), for example, is being widely advertised in the general practitioner press but I would not recommend it for use by general practitioners as psychiatrists have not yet got a feel for it. I wondered why this and other new drugs such as paroxetine and amoxapine were not discussed in the Matthews and Eagles' article. Then I realized that it had been submitted in January 1990.

The article advocated the use of trazodone, mianserin and lofepramine as first line drugs. It was not stated whether this was intended to be an order of preference, but it may well have been understood as one. There are almost no adverse effects from lofepramine and it is commonly used. Trazodone is less popular, probably because of the priapism which it occasionally causes and is hard to treat. Mianserin can cause blood dyscrasias so full blood counts need to be carried out, at least initially. Overall, lofepramine emerges as the best of the three.

Fluvoxamine was suggested for depressive disorders where obsessional symptoms predominate. Fluoxetine is put in the same category but this drug is mentioned only once. I found this surprising as it has been an extremely popular antidepressant internationally and is becoming increasingly so in the UK. Over three million patients have now been treated with the drug. I am sure readers were hoping to hear psychiatrists' views of the recent adverse publicity about fluoxetine. It seems to be an effective drug which is relatively free of adverse effects. In particular it causes nausea much less frequently than fluvoxamine and many psychiatrists consider that this makes it a superior drug to fluvoxamine.

A recent television documentary suggested that fluoxetine might cause some patients to commit suicide by violent means. However, there are no controlled trials to prove that the phenomenon exists, only case reports and these can sometimes be misleading. Depressed people sometimes commit suicide by violent means and some of them are bound to be taking a commonly prescribed antidepressant. If this is a real phenomenon, there are two possible explanations for it. The less likely of the two is that there is something about the drug that gives rise to a 'side effect' of violent suicide. More likely is that patients' motivation picks up more quickly than their mood, making the chance of suicide temporarily greater. The answer may not be to stop using fluoxetine but to warn patients of this danger and monitor them particularly closely in the early phase of recovery from depression.

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Diplomatosis

Sir,

According to Dr Brown (Letters, March *Journal,* p.128) the MRCGP examination represents an endpoint assessment leading him to question the value of diplomas in core subjects like child health and geriatric medicine. He also reports that diplomas were not welcomed at a general practitioner trainee conference he attended, levelling the charge that diplomas represent nothing more than a convenient source of income to respective colleges. I think this aspersion unworthy, even anomic. He did concede, however, that diplomas were important if they represented experience and specialization. I would like to express my views as I have advocated the diploma in geriatric medicine since 1978 and am the only examiner for both it and the MRCGP examination.

The high rate of interest in the DRCOG reflects little more than its value at job interviews — it is an anachronism now that few general practitioners are involved with intra-partum care and much antenatal care is quite rightly delegated to an attached midwife. The DCH is highly specialized, and less relevant to general practice than might be supposed, since questions appear on rare diseases of childhood that are, in practice, cared for by paediatric registrars.

I would agree that diploma studies should not disrupt the general practice year or specialty attachments. However, the MRCGP examination is a wide ranging assessment in which it is highly unlikely the candidate will be asked much if anything about geriatric care, despite the fact that in the average practice 16% of patients are over 65 years old. It was only in 1980 that the first question on the elderly was asked in the MRCGP examination. Even candidates for the DGM have a high failure rate in questions on biological theories of ageing, tardive dyskinesia and emotional lability. Candidates are now better informed on rehabilitation, though many show a surprising lack of acquaintance with everyday aids and appliances, and of what is meant by enduring power of attorney, testamentary capacity, and the court of protection. From the examiner's point of view, the great advantage of the DGM is the ability to see the candidate relating to a real patient, a limiting factor in the MRCGP examination.

General practitioner principals and trainees make up a considerable proportion of the candidates for this successful diploma, for which enjoyment in participation and widespread tributes to its relevance are often expressed. The unprecedented biological trend towards longer life in developed countries makes the diploma in geriatric medicine an essential requirement for general practitioners who attend the needs of 94% of the elderly population.

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