

# Letters to the Editor

## Assessing Sexual Function of Patients Before Initiating SSRI Therapy

**Sir:** The recent article in the *Companion* by Dr. Ferguson on the adverse effects and tolerability of selective serotonin reuptake inhibitors (SSRIs)<sup>1</sup> is a superb review of the common side effects associated with one of the most widely prescribed medication classes in the United States. As more patients are diagnosed with depression, in large part due to earlier recognition and intervention on the part of primary care physicians, more patients will be offered antidepressant therapy with its attendant risks (i.e., side effects).

The discussion about sexual dysfunction highlights the importance and necessity of physicians who prescribe SSRIs, or any psychotropic, to obtain a thorough sexual function history, not only because patients may not disclose this information unless prompted, but also because the dysfunction may be due to their psychiatric illness. By obtaining a baseline level of functioning prior to initiating antidepressant therapy, physicians may also uncover sexual dysfunction that is present, since it has been estimated that up to 41% of women and 31% of men have sexual dysfunction.<sup>2</sup> By distinguishing the preexisting condition from side effects of the SSRIs, clinicians may properly treat the condition instead of unnecessarily discontinuing agents or adding agents that could possibly complicate the problem even further with their own set of unwanted side effects. Some preexisting conditions may also respond to nonpharmacologic therapies; thus, as Dr. Ferguson points out, it is extremely important to obtain a thorough sexual function history to better treat our patients.

Conclusions and opinions expressed are those of the author and do not necessarily reflect the position or policy of the U.S. Government, Department of Defense, Department of the Army, or the U.S. Army Medical Command.

### REFERENCES

1. Ferguson JM. SSRI antidepressant medications: adverse effects and tolerability. *Primary Care Companion J Clin Psychiatry* 2001;3:22-27
2. Laumann EO, Palik A, Rosen RC. Sexual dysfunction in the United States. *JAMA* 1999;281:537-544

**Timothy R. Berigan, D.D.S., M.D.**  
William Beaumont Army Medical Center  
El Paso, Texas

## Oxcarbazepine in Bipolar Disorder

**Sir:** Dr. Berigan's otherwise thorough overview of newer anticonvulsants in psychiatry<sup>1</sup> requires comment with regard to oxcarbazepine. The first double-blind study was placebo con-

trolled and published in 1983, not 1985.<sup>2</sup> Six rather than 7 patients were involved (1 was treated on 2 occasions, making a total of 7 trials) in an A-B-A crossover design of unspecified duration with a mean improvement in Inpatient Multidimensional Psychiatric Scale scores of 49.9%, not 86%.

That study led to 2 double-blind multicenter trials of 2 weeks' duration that were not mentioned by Dr. Berigan. One compared oxcarbazepine with haloperidol, and the other compared oxcarbazepine with lithium in patients with acute mania.<sup>3</sup> In both studies, oxcarbazepine and the comparator drug were of equal efficacy, and improvements in mania ratings were substantial, lending support to the impression that oxcarbazepine has considerable antimanic activity. These studies were limited by relatively small sample sizes, meager description of study design and outcome, and lack of placebo control. Patients in the haloperidol study were recruited from 3 countries, and patients in the lithium trial came from 5 countries on 3 different continents.

Since its introduction in the United States as an antiepileptic drug in early 2000, oxcarbazepine is becoming increasingly more popular for use in bipolar disorder, although there are, as yet, no published "modern" studies of its effectiveness for that condition.

### REFERENCES

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2. Emrich HM, Altmann H, Dose M, et al. Therapeutic effects of GABA-ergic drugs in affective disorders: a preliminary report. *Pharmacol Biochem Behav* 1983;19:369-373
3. Emrich HM. Studies with oxcarbazepine (Trileptal) in acute mania. *Int Clin Psychopharmacol* 1990;5(suppl 1):83-88

**James W. Jefferson, M.D.**  
Madison Institute of Medicine, Inc  
Madison, Wisconsin

## Dr. Berigan Replies

**Sir:** I wish to thank Dr. Jefferson for his highly valued comments regarding my recent letter to the editor.<sup>1</sup> It is an honor that such a renowned physician has taken the time to clarify an unintended oversight.

### REFERENCE

1. Berigan TR. Psychiatric uses of newer anticonvulsants [letter]. *Primary Care Companion J Clin Psychiatry* 2001;3:82-84

**Timothy R. Berigan, D.D.S., M.D.**  
William Beaumont Army Medical Center  
El Paso, Texas