

Off-label 'experiments'?

If I am correct, your editorial ("Off-label prescribing," CURRENT PSYCHIATRY, March 2007, p. 15-6) appears to invite those without adequate experience and knowledge—myself included—to experiment, come up with their own combinations, and engage in off-label prescribing. Although off-label prescribing is important, it is not justified by your statement that "compassionate practitioners use whatever is available to alleviate suffering."

I think it is best to warn clinicians that off-label prescribing should be based on reason, knowledge, and good clinical judgment after conventional and accepted treatments have proven ineffective—in which case it would be advisable to review the initial diagnosis and obtain opinions from more experienced colleagues or well-established experts.

I say enough with the current status of our profession, which allows for permanent gross deficiencies in diagnosing techniques, outrageous treatments, and many skeptical and contemptuous looks from colleagues in other specialties. Your editorial seems to sanction encouragement of primary care physicians to detect and treat depression, with the sad result that only 20% of depressed patients in primary care receive adequate pharmacological treatment, according to a recent study.¹

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Reference

1. Lecrubier Y. Widespread underrecognition and

undertreatment of anxiety and mood disorders: results from 3 European studies. *J Clin Psychiatry* 2007;68(suppl 2):36-41.

important observations and data during this process that can be leveraged into future treatment indications.

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Dr. Nasrallah Responds

In my editorial I was not encouraging off-label use but suggesting that the practice is inevitable due to the pervasive lack of approved drugs or controlled studies for many psychiatric diagnoses.

Experienced psychiatrists sometimes focus on severe target symptoms rather than a syndrome and may choose to use a drug approved for another disorder that has a clear therapeutic effect. For example, various psychiatric disorders share symptoms such as anxiety, depression, impulsivity, agitation, aggression, or hyperactivity. In the absence of an approved agent, clinicians are likely to use medications approved for bipolar disorder for a different psychiatric illness, such as a traumatic brain injury, that may share some but not all the symptoms of bipolar disorder. The patient gets some relief from symptoms and, until a drug is officially approved for that condition, off-label use arguably is a reasonable mode of action for a patient who may harm himself or others.

My editorial did not encourage primary care colleagues to use psychotropic drugs off-label. Primary care providers usually diagnose and treat anxiety and depression, which have several approved therapeutic agents. These physicians should refer patients with serious psychiatric conditions that have no approved drugs to a psychiatrist for diagnosis and management.

Off-label practices will continue as long as there are DSM-IV-TR diagnostic categories that do not have an approved drug. Medical practitioners can generate