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The authors' reply:

We agree with a number of points raised by Dr Chris Muldoon in his letter. In particular we agree that it is advisable to limit the quantity of antidepressants prescribed for many (although not all) patients and that treatment should be supervised and/or monitored. We agree also that there is evidence that the older TCAs are more toxic in overdose than newer antidepressants, although it has to be acknowledged that controversy remains about whether new or old drugs should be prescribed as first-line treatment of depression.[1-5]

However, we disagree with Dr Muldoon's statement that we have presented broad generalisations on the basis of disparate studies. It is important to distinguish the first part of our paper,[6] in which we presented a systematic review and meta-analysis of the efficacy and tolerability of comparative studies of SSRIs, from the second part, in which we carried out a more conventional review of comparative data on unwanted effects and toxicity in overdose. We acknowledge that these data were from selected sources, but believe that they complement the meta-analysis and have to be taken into consideration in an overview leading to practical guidelines.

The publication by Barbey and Roose[7] was not available when we wrote our paper but appeared in print while ours was in press. We have since reviewed the paper in which it is stated that 15 cases of overdoses of citalopram were encountered among 4422 patients treated with the drug in trials and that none of them was fatal. The authors also stated that 2 deaths due to an overdose of citalopram alone occurred during post-marketing surveillance. One of these was included in the Östrom et al.[8] series. The other occurred in a 17-year-old woman who ingested 2800mg of the antidepressant (140 times the usual daily dose of 20mg).

Whenever possible we presented in our paper[6] guidelines that were evidence-based but there were areas where this could not be done. In these areas we had no alternative than to offer weaker recommendations. We believe that our comments on citalopram fell into this category; they were not reported as firm conclusions. We mentioned in our review the 6 fatal cases reported by Östrom et al.[8] – individuals in whom co-ingested drugs were considered not to have contributed to the deaths – but also summarised the main points in the follow-on correspondence in the *Lancet* that put the cases in perspective and threw doubt on the alleged mechanism of death. Thus, we looked at the overdoses from a similar perspective to that of Barbey and Roose.[7]

We could not report any new data on the effects of overdose in the review section of our publication[6] as none had been published between the time Östrom et al.[8] published their letter and the time we wrote our paper.[6] Nothing is certain in medicine and, while there is a remote possibility that citalopram could have contributed to the deaths, some clinicians might decide to err on the side of safety and not choose citalopram as first-line treatment given the availability of suitable alternative drugs. We freely accept that it is possible to draw a different conclusion from the data. Inevitably, value judgements have to be made when interpreting data of the kind reviewed in our paper.[6]

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