

ical nutrition case, but I thought that psychological factors should have been considered in the case discussion. Why exactly was Mr. B. not eating? Why did his food not appeal to him? Surely there was more going on than an inability to reach his food. Mr. B. could very well have been suffering from clinical depression; if it were properly treated, his appetite would improve and his protein-energy malnutrition would be reversed.

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Reference

1. Hoffer LJ. Clinical nutrition: 1. Protein-energy malnutrition in the inpatient. *CMAJ* 2001;165 (10):1345-9.

[The author responds:]

My article described protein-energy malnutrition as a pathologic entity with specific causes, the

most common of which by far is simple starvation. Bruce Williams's suggestion that depression could explain my patient's inadequate food intake is excellent, but he might have asked a broader question: Why do 25% or more of hospital inpatients starve in the midst of apparent plenty? Mr. B.'s story was inspired by a real case. My patient was certainly unhappy and discouraged. Who wouldn't be in his situation? No one had diagnosed psychiatric depression, but neither was it ruled out. If he was depressed, would antidepressant therapy have hastened his recovery? Possibly, but only if it did not delay or replace the holistic intervention described in the case history. Unfortunately we have no systematic information about the role of mental illness as a cause of starvation (nor, conversely, about starvation's role in precipitating or exacerbating mental illness) in hospitalized patients. Several factors are probably involved.¹ For example, patients who don't eat

enough food will predictably be micronutrient starved. Deficiency of certain micronutrients, especially folic acid, precipitates depression.² Folic acid administration improves the clinical outcome even of apparently nourished, yet depressed, patients.^{3,4} However, few starving patients are prescribed vitamin supplements.

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References

1. Sarkisian CA, Lachs MS. 'Failure to thrive' in older adults. *Ann Intern Med* 1996;124(12):1072-8.
2. Bottiglieri T, Laundy M, Crellin R, Toone BK, Carney MW, Reynolds EH. Homocysteine, folate, methylation, and monoamine metabolism in depression. *J Neural Neurosurg Psychiatry* 2000;69 (2):228-32.
3. Godfrey PSA, Toone BK, Carney MWP, Flynn TG, Bottiglieri T, Laundy M, et al. Enhancement of recovery from psychiatric illness by methylfolate. *Lancet* 1990;336(8712):392-5.
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McNeil

Children's Motrin

2 x 1/2 pages, 4 clr.

Repeat of Apr. 16