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Reply

We welcome the comments made by Hasnain and Vieweg in their Letter that supports all of the points for the potential benefits of metformin coadministered with antipsychotic medications made in our discussion paper (1). We agree that it is not entirely clear whether metformin should be used routinely as a preventative strategy. However, there is sufficient evidence to warrant metformin intervention when cardiometabolic complications arise in antipsychotic recipients and an increased interest in the more widespread use of metformin in this population (2–4).

We have developed a clinical resource that recommends thresholds where metformin use could be routinely considered (5).These include: weight gain of >5 kg or waist circumference gains of >5 cm from baseline, prediabetes and polycystic ovary syndrome where non-pharmacological interventions have been trialled and not resulted in achieving recommended targets. It is known that the overwhelming majority of people who are prescribed antipsychotic medication will develop weight and cardiometabolic complications and for those that do, there are inevitable serious health consequences that include a shorter life expectancy. Further, some patients may be completely deterred from taking antipsychotic medications because of the possibility of weight gain. Hasnain and Vieweg suggest that a point system should be utilized to determine those most likely to benefit from metformin use. Whilst well thought out, we anticipate that such an approach may create barriers to clinicians addressing the metabolic complications of antipsychotic medications. Our principal responsibility is to engage with our patients in a meaningful discussion about risks and benefits of antipsychotic treatment, including the coadministration of metformin.

We believe that the current evidence is such that an informed patient might choose to take metformin as a preventative measure before cardiometabolic complications have emerged. We look forward to a time when all patients will routinely be offered comprehensive cardiometabolic protection when antipsychotic medications are prescribed. A comprehensive approach to cardiometabolic protection must include smoking cessation, lifestyle intervention addressing diet and sedentariness, as well as safe preventative medical treatments.

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Did Karl Jaspers miss psychiatry or is psychiatry missing Jaspers' legacy?

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The approach to modern psychiatric diagnosis originated from the work of Karl Jaspers (1). His *Allgemeine Psychopathologie* (General Psychopathology, GP) was first published in 1913. The first English translation appeared in 1963, but by this time, it expanded and progressed to the seventh edition (2). Arguably the English translation of the late edition provides no gateway to the panoramic view of the early 20th-century philosophical construction and deconstruction and Jaspers' original thinking (for e.g., in GP footnotes referring to Husserl's phenomenology disappeared over decades) (3). However, for many readers, only the English translation of the late edition is available. Writing one-page note on Jaspers' vast and complex work is a daunting task. Nevertheless, it is a necessary one, and this letter attempts to brief essential concepts and their place in current practice along with dramatic turns in Jaspers' life.