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High-dose antipsychotic medication

SIR: The problems of using high-dose antipsychotic medication are highlighted by Thompson (for the Royal College of Psychiatrists' Consensus Panel) (*BJP*, April 1994, **164,** 448–458, 1994) and Kane (*BJP*, April 1994, **164,** 431–432).

We have successfully reduced high-dose regimens in a number of patients with severe, chronic schizophrenia, in both in- and out-patient settings.

Case 1 is a 50-year-old married woman, an out-patient since her last admission 10 years ago, and maintained on daily doses of 600 mg chlorpromazine, 600 mg lithium, 60 mg diazepam (20 mg three times daily) and 20 mg procyclidine, together with 500 mg zuclopenthixol decanoate at 4-weekly intervals. In October 1993 we introduced treatment with risperidone, rising to a dose of 3 mg twice daily. At the same time, her other treatments were cautiously reduced, under the supervision of her community psychiatric nurse. Chlorpromazine was gradually withdrawn by reducing the dose by 50 mg each day over a period of two weeks, depot zuclopenthixol injections are similarly being reduced by 50 mg at each 4-weekly injection, diazepam was reduced to 5 mg three times a day, and both lithium and procyclidine were discontinued. Following the introduction of risperidone and the gradual reduction of her other medication, there has been a significant change in the patient's mental state. Not only has there been no return of active psychotic symptoms but she has changed from taking no part in family life to being able to manage home and kitchen duties and being active in conversations.

Three other out-patients with similar clinical and drug histories have gradually been switched to risperidone. All have succeeded in gradual transition without relapse and have experienced a return of interest, activity and social involvement. One example is case 2, a 34-year-old man maintained for a number of years on daily doses of 800 mg chlorpromazine, 40 mg zuclopenthixol, 10 mg diazepam and 20 mg procyclidine. He had a history of severe psychosis and violence, with little recent progress. He is now managed on 4 mg risperidone twice daily, having cooperated enthusiastically in the withdrawal of his other medication. His negative symptoms have ameliorated, he is more at ease with himself and appears to enjoy a better quality of life than before.

Patients may be weaned off high doses of neuroleptics and successfully maintained on risperidone. In such patients, gradual dose reduction of conventional neuroleptics is important in maintaining patients' confidence and to avoid rebound Parkinsonism which has been observed after more sudden withdrawal following very long-term treatment.

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Sinus bradycardia due to fluvoxamine overdose

SIR: We report a case of fluvoxamine cardiotoxicity that manifested as marked bradycardia, and required close medical monitoring.

Case report A 58-year-old woman with a bipolar affective disorder had been hospitalised due to a major depressive episode. Therapy with fluvoxamine was commenced at a daily dose of 250 mg. After a month of treatment, improvement was noted. A night prior to her scheduled discharge she attempted suicide by ingesting 5.5 g of fluvoxamine. On examination several hours later the patient was pale, severe sinus bradycardia was found (32 beats per minute), and she complained of severe fatigue. No medical intervention was necessary due to stable haemodynamic parameters. The patient returned to normal sinus rhythm within a couple of days.

Henry *et al* (1991) reported on sinus bradycardia in 15 of 310 cases with fluvoxamine overdose. Most patients had mild adverse effects, none of which required treatment. It is not clear what the direct cause of bradycardia was.

Szabadi (Burton, 1991) referred to this issue by mentioning that fluvoxamine blocks muscarinic responses. Although its antimuscarinic potency is a third of that of amitriptyline, it is usually prescribed at higher doses. In addition, high single doses of fluvoxamine seem to block β1 and β2 adrenoreceptors, as is shown by the reduction of exercise-induced tachycardia. Therefore, the muscarinic and β-blocking activities of fluvoxamine may account for the appearance of severe sinus bradycardia, and for some unexplained deaths following fluvoxamine overdose (Garnier *et al*, 1993).

BURTON, S. W. (1991) A review of fluvoxamine and its uses in depression. In "*Fluvoxamine* – new perspectives in clinical practice". *Psychopharmacology,* **6** (suppl. 3), 18.

GARNIER, R., AZOYAN, P., CHATAIGNER, D., *et al* (1993) Acute fluvoxamine poisoning. *Journal of International Research,* **21,** 197–208.

HENRY, J. A. (1991) Overdose and safety with fluvoxamine. *International Clinical Psychopharmacology*, **6** (suppl. 3), 41–47.

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Treatment of drug-induced anorgasmia

SIR: Arnott & Nutt (*BJP*, June 1994, **164**, 838–839) reported the treatment of fluvoxamine-induced anorgasmia with cyproheptadine. Fluoxetine-induced anorgasmia has been successfully reversed with both cyproheptadine and yohimbine, an alpha-2 antagonist (Segraves, 1993). I would like to report the successful treatment of six cases of sertraline-induced anorgasmia (2 men, 4 women) and four cases due to paroxetine (3 men, 1 woman), with 5.4 mg yohimbine taken approximately 1–2 hours prior to planned coitus. To date, all cases of serotonin reuptake inhibitor-induced anorgasmia encountered in my practice have responded to small, appropriately timed doses of yohimbine.

SEGRAVES, R. T. (1993) Treatment-emergent sexual dysfunction in affective disorder. *Journal of Clinical Psychiatry*, **11** (monograph 1), 1–4.

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Violence in psychiatric units

SIR: Studying violent incidents in psychiatric units, Walker & Seifert (*BJP*, June 1994, **164**, 826–828) found that nurses were assaulted most often. Nurses make up the majority of the staff on most psychiatric units, and the greater frequency of assault may simply reflect their greater numbers and increased patient contact.

The authors suggest that a forensic history is a predictor of violent behaviour as an in-patient, and that this should be used as an indication that these patients should receive extra attention. Taking this as a screening test, where a forensic history is used as an indicator, a forensic history provided a sensitivity of 0.81 and a specificity of 0.69. Predictive values are of greater use in assessing the value of a screening test in routine practice and the positive predictive value of a forensic history in this population was 0.56 (i.e. 56% of those with a forensic history would assault). In effect, the use of this as a screening test would result in twice as many patients being identified as potentially assaultive as would eventually assault. Our concern would be that staff would recognise that the forensic history was a blunt predictive instrument, and would relax their vigilance over time.

Walker & Siefert's work confirms the frequency of violent behaviour, and emphasises the need for appropriate training. The limited help provided by aspects of the clinical history lead us to believe that it is essential to strive to develop safe systems. Rather than staff relying on the identification of high risk patients, ward and hospital management should endeavour to create safe environments by the appropriate use of observation, alarm systems, staff support and training.

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Male erotomania and dangerousness

SIR: Boast & Coid (*BJP*, June 1994, **164**, 842–846) describe a case of male homosexual erotomania featuring dangerous behaviour directed at the delusional object, and comment that the question of dangerousness in such cases remains unresolved.

When discussing dangerousness in relation to erotomanic delusions it is useful to distinguish between dangerous behaviour related to the delusions, such as assault on the object or 'rival', and unrelated dangerous behaviour which may precede the onset of the delusions. In a sample of 27 cases of men with erotomanic features (Menzies *et al*, in press), we found that dangerousness (related to the delusions) was significantly associated with both the presence of multiple delusional objects ($P<0.0005$) and dangerousness unrelated to any erotomanic delusion ($P<0.05$). The only cases which exhibited dangerous behaviour (related) had either multiple delusional objects (42%) or a history of unrelated dangerous behaviour (25%) or both (33%).

Boast & Coid did not report any other delusional attachments in their case but there was a history of an assault, unrelated to the erotomanic delusion, and an additional diagnosis of personality disorder. They referred to two other cases of male homosexual erotomania. One (Doust & Christie, 1978), with a single object, exhibited no dangerous behaviour, while the other (Peterson & Davis, 1985), with