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Letters to the editor

Withdrawal symptoms associated with paroxetine

L Mannion, PA Carney

Department of Psychiatry, University College Hospital, Galway, Ireland

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Paroxetine is a potent selective serotonin reuptake inhibitor (SSRI), with a half-life of approximately 1 day. Withdrawal syndromes have been reported to occur with other SSRIs, including fluoxetine, sertraline and fluvoxamine (Szabadi, 1992; Louie et al, 1994; Einbinder, 1995). More recently, paroxetine has been implicated in similar withdrawal syndromes. We wish to add a further three cases to those described previously (Barr et al, 1994; Debattista and Schatzberg, 1995; Pyke, 1995).

The patients involved were three physically healthy women (aged 25–42 years). Each had an uncomplicated diagnosis of major depression, and was treated as an outpatient. Paroxetine was commenced at a dose of 20 mg/day and was tolerated well by all patients. One patient's medication was increased to 40 mg/day after some time. Paroxetine was the only medication prescribed and was continued over a treatment period of 8–12 months. All patients responded well, with full remission of symptoms in two cases, and the other patient showing a partial response. In two cases, following agreement on discontinuation of treatment, paroxetine was reduced to 10 mg/day for 2 weeks, continued on alternate days for a further 2 weeks and then discontinued. Both of these patients reported symptoms of dizziness, vertigo, headache, tremor and a subjective sense of gait instability and 'jitteriness' on discontinuation of their medication. One patient left work abruptly because she felt so unwell. The symptoms persisted for approximately 5–7 days.

The third patient had been prescribed 40 mg/day and on reaching the end of her supply, found she had mislaid her prescription. She experienced similar withdrawal symptoms on omitting her medication. On recommencing paroxetine at 20 mg daily, her symptoms resolved. She currently remains on this dose.

Paroxetine is more antimuscarinic in effect than other drugs of the SSRI class. It has been suggested that withdrawal symptoms encountered may be mediated by cholinergic rebound (Pyke, 1995), similar to that occasionally seen in abrupt discontinuation of tricyclic antidepressants. Debattista and Schatzberg (1995) discount this suggestion, arguing that it is unlikely that low doses of a relatively weak antimuscarinic agent such as paroxetine could result in substantial cholinergic rebound. They suggest that it is more likely that these symptoms represent serotonin rebound phenomena. The similarity of some of the symptoms reported to those seen in the serotonin syndrome (eg, tremor, restlessness, etc) could support this hypothesis.

What is again striking from a clinical point of view, is the appearance of withdrawal symptoms despite gradual tapering of dose over a 4 week period. It is clear that some patients may require very gradual reduction of medication to low doses over a period of some weeks.

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Possible delayed venlafaxine withdrawal reaction: two case reports

N Jacobson, R Weiber

Department of Psychiatry, Central Hospital, S-29185 Kristianstad, Sweden

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Withdrawal reactions to the antidepressant venlafaxine have been described (Faraii and Lauer, 1996). We report two cases of possible venlafaxine withdrawal reaction with delayed onset of symptoms.

In the first case, Mr A, 42 years old, had a history of more than 10 years of dysthymia. He had incessant suicidal ideation with recurrent suicidal threats, but had never made any drastic suicidal attempt. Several antidepressant drugs had been tried with limited success. After 5 months on 150 mg venlafaxine daily, he was admitted to our hospital due to increased anxiety and feelings of unbearable loneliness. The dose of venlafaxine was decreased to 75 mg daily and discontinued 2 days later, when instead citalopram 10 mg daily was started. After a further 9 days of treatment, seemingly more stable, Mr A was on a planned leave to his home. There, he experienced the most intense anxiety attack he ever had, with overwhel-