

Correspondence

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Sertraline-induced anorgasmia reversed by nefazodone

Sir: Delayed or absent ejaculation and/or orgasm is a common side-effect of antidepressant drugs. Attempts to reverse this with cyproheptadine, amantadine, methylphenidate, yohimbine, dosage reduction, drug holidays and drug substitution have had mixed results. We report a case of sertraline-induced anorgasmia reversed by the addition of nefazodone.

A 60-year-old married man was referred with a moderate depressive episode of three months' duration. Prior to the onset of depression he was sexually active. Since the onset of depression he had moderate decrease in libido and mild decrease in the frequency of sexual intercourse. His depression improved with sertraline 10 mg daily for four weeks. However, his libido remained low and he became unable to attain ejaculation/orgasm. The distressed couple considered giving up the medication. He was prescribed nefazodone 100 mg at bedtime, in addition to the sertraline. He had immediate return of normal ejaculatory function. Over the following fortnight they also noticed an increased frequency of sexual intercourse. After two weeks of normal orgasm with nefazodone, he tried to have sexual intercourse without nefazodone but again failed to ejaculate. Hence, he started using nefazodone on an 'as and when required' basis, an hour before having sexual intercourse.

There has been one previous report of nefazodone reversing antidepressant drug-induced anorgasmia (Reynolds, 1997). Nefazodone inhibits serotonin reuptake and blocks 5-HT₂ receptors, resulting in the facilitation of 5-HT_{1A} neurotransmission. Both 5-HT₂ blockers and 5-HT_{1A} agonists facilitate male rat sexual behaviour (Pfaus & Everitt, 1995). This may explain the reports of nefazodone causing spontaneous ejaculations (Michael & Ramana, 1996) and correcting antidepressant drug-induced anorgasmia (Reynolds, 1997).

Sexual side-effects of antidepressant drugs cause distress, strain relationships, impair quality of life and reduce compliance with treatment. Controlled trials are needed before recommending nefazodone as a routine treatment for antidepressant-induced anorgasmia.

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Acute manic symptomatology during repetitive transcranial magnetic stimulation in a patient with bipolar depression

Sir: Repetitive transcranial magnetic stimulation (rTMS) may be useful in medication-resistant depression (Reid *et al*, 1998; George *et al*, 1999). If appropriate safety guidelines are followed, rTMS appears to have very few side-effects (Wassermann, 1998). However, I report a case where rTMS may have triggered manic symptoms temporarily.

A 44-year-old man with a 20-year history of bipolar disorder was hospitalised with a severe manic episode. Seven days after adjustment of medications (zuclopentixol, carbamazepine, clonazepam and biperiden) he became increasingly depressed with psychomotor retardation and hopelessness. His score on the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) was 31. Medications remained

unchanged and rTMS was applied with an 8-shaped coil to the left dorsolateral prefrontal cortex (at 20 Hz and 90% motor threshold intensity, in 30 trains of 2 s duration and 30 s intertrain intervals). During the first rTMS session the patient started laughing and repeatedly expressed elation and sexual desires. The patient's mood fluctuated markedly from euphoria to despair between trains. Such rapid fluctuations had never before been observed in this patient. A few hours later the patient appeared as depressed as prior to the rTMS. Stimulation sessions on the following two days led to similar acute effects, but the patient's overall mood improved on day three (HRSD 12). We withheld rTMS owing to concerns of precipitating a lasting manic phase. Two weeks later the patient's HRSD score was 35 and further rTMS was applied. Despite applying the same protocol, the patient did not show sudden mood swings. He received seven sessions on consecutive days and derived a significant clinical benefit (HRSD 14). Medications were unchanged during rTMS treatment. Seven months later he continues euthymic (HRSD 9).

In a patient with bipolar disorder and a recent phase switch, the temporal coincidence of manic symptoms and rTMS application might be a chance occurrence. However, the reproducibility of the effects on three consecutive days suggests otherwise. It seems plausible that given its antidepressant effects, rTMS might have the risk of triggering mania in bipolar depression, as is the case with antidepressant medications and electroconvulsive therapy. This emphasises the need for careful clinical observation and study design.

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