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More cases of paroxetine withdrawal syndrome

SIR: We wish to add five more cases of paroxetine withdrawal syndrome to those reported by other authors (Barr *et al*, 1994; Pyke, 1995).

All of our cases occurred in young women (aged 26–39 years), without concurrent organic illness, diagnosed with major depression. Paroxetine was started at a dose of 10 mg/day in the first week and increased to 20 mg for the rest of the treatment period (12–14 months). The drug was well tolerated and laboratory tests were always normal throughout the period. A benzodiazepine was used during the first 2–3 months as an adjunct to manage anxiety but paroxetine was, thereafter, the only maintenance treatment.

In three cases paroxetine was discontinued by alternating 20 mg one day and 10 mg the other day during a week. After that, 10 mg/day was maintained for 15 days, then patients were prescribed 10 mg every other day for one more week, before stopping medication. In two patients the tapering was done directly from 20 to 10 mg and after 2 weeks on this dose they stopped the medication.

All patients complained of vertigo, light-headedness or gait instability during withdrawal. Three patients referred to the symptoms in their next planned out-patient consultation, but two demanded urgent treatment and were prescribed lorazepam 1 mg/day for one week. In all five cases, the symptoms persisted for approximately 7 days.

Very similar withdrawal syndromes have been described with other serotonin selective reuptake inhibitors including fluvoxamine, fluoxetine and sertraline, and muscarinic and serotonergic factors have been implicated in the production of these symptoms but what is striking from a clinical point of view is the fact that a conservative tapering regime was unable to prevent symptoms appearing. As a result of this experience we are now applying a dosage reduction of 5 mg per week in an attempt to avoid this withdrawal syndrome.

BARR, L. C., GOODMAN, W. K. & PRICE, L. H. (1994) Physical symptoms associated with paroxetine discontinuation (letter). *American Journal of Psychiatry*, **151**, 289.

Yohimbine and sinusitis

SIR: There is clinical evidence that yohimbine has an effect in restoring erectile capacity in men with erectile dysfunction (ED) but may be accompanied by side-effects.

Case report

A 59-year-old man described a 3 year history of erectile dysfunction. After discussing treatment options he chose oral medication. A trial of yohimbine 5.4 mg tid. was initiated. Three days after starting medication he developed pain and discomfort above both eyes which he described as like 'a thick head cold'. The area was tender to touch but there were no other symptoms to suggest sinus problems, influenza or an anxiety state. There was no change in his mental state. He stopped medication and symptoms resolved within 24 hours. A week later he re-exposed himself to the tablets and symptoms returned after three days, and again resolved within 24 hours of stopping. During each treatment period, no success was noted with sexual function. The patient refused a third trial of yohimbine with phenylephrine cover.

Yohimbine is an alpha-2-adrenergic antagonist. Sinus congestion is treated with a decongestant agent like phenylephrine, a direct acting alpha agonist which causes peripheral vasoconstriction. It is possible that the described symptoms are a consequence of alpha-2-adrenergic antagonism affecting the sinus mucosa. This may explain the delay in onset of symptoms similar to the latent clinical response of the drug. Side-effects would be expected to occur rapidly given the short plasma half life of 35 minutes (Owen *et al*, 1987). There are no reports in the literature associating yohimbine and sinusitis,

headache or migraine, although the data sheet mentions headache reported to the company.

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ONE HUNDRED YEARS AGO

Epidemic insanity

An extraordinary account of an outbreak of insanity has been reported in which first two brothers and then three sisters became violently mad in Skibbereen, Ireland, some of the patients being sent to the Cork Asylum. Various theories have been propounded as to the causation of this outbreak. It is not very unusual to meet with instances where two members of a family break down as the result of some common cause, generally the insanity of a member of the family, and in most instances the cases are very transient and hysterical in character. The so-called 'folie à deux'

may involve more than two, and we know that in Roman Catholic countries like Ireland an epidemic of a religious character may arise and spread far and wide. We do not think the outbreak under consideration is likely to have depended on the food taken, as has been suggested, and we should be inclined to attribute considerable etiological importance to nervous heredity and a kind of expectancy which easily gives rise to the real disorder.

Reference

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