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## Mania precipitated by carbamazepine withdrawal

SIR: The anticonvulsant carbamazepine is as effective as lithium in the prophylaxis of bipolar affective disorders (Coxhead *et al*, 1992) and may be considered as a possible alternative to it. There has been a debate about whether discontinuation of lithium may precipitate a rebound manic or depressive episode (Schou, 1993). Carbamazepine has not been thought to have any affective withdrawal effects. We wish to report the case of an epileptic woman in whom withdrawal of carbamazepine has twice precipitated a manic episode.

MK is a 30-year-old who has had complex partial seizures for 12 years. Neurological examination is normal. Her EEG shows bi-temporal or left fronto-temporal abnormalities. CT and MRI examinations are normal.

She has taken carbamazepine for her epilepsy for 10 years. Seizures have continued despite doses up to 1000 mg bd. Recently valproate, 2500 mg per day, then phenytoin, 200 mg per day, were added and carbamazepine gradually withdrawn.

Five days after stopping carbamazepine she had a single nocturnal fit. Two days later she presented complaining of insomnia, poor appetite, increased energy and racing thoughts. Elated mood alternated with brief episodes of dysphoria and suicidal ideation. She was distractible and mildly disinhibited. There was some pressure of speech. She felt 'more sensitive' than usual but did not appear hallucinated or deluded. Her EEG taken at presentation was unchanged and excluded complex partial status. Carbamazepine was restarted and the dose gradually increased to 300 mg bd. Her mood settled over three weeks and has remained stable for several months.

Her previous psychiatric history is of a single episode of mania. This started four days after abruptly stopping carbamazepine two years earlier. It was characterised by mildly euphoric mood, a sense of cosmic importance "like being god", agitation and poor sleep. She responded to reintroduction of carbamazepine and addition of chlorpromazine.

MK's symptoms fit ICD–10 diagnostic guidelines for a manic episode. On both occasions her manic illness responded to the reintroduction of carbamazepine. We are not aware of any other reports of carbamazepine withdrawal being associated with a manic episode.

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## Laryngeal dystonia

SIR: I read with interest the letter describing neuroleptic induced dysphonia (Thorburn, 1995). Dystonia of the laryngeal muscles can be frightening and is easily missed, as the following case report illustrates.

A 14-year-old male on no medication and with no past psychiatric history was admitted following an overdose of 500 mg chlorpromazine and 80 mg of fluoxetine in addition to approximately 8 units of alcohol. A good result from a stomach washout was reported within four hours of the overdose. Thirty-six hours later he experienced difficulty in speaking followed rapidly by a choking sensation. This resolved spontaneously and the incident was recorded as a panic attack. The following day his intermittent problems with vocalisation were attributed to anxiety; a psychiatric assessment was hindered by his fluctuating but severe dystonia involving muscles of the head, neck and trunk. Laryngeal dystonia rendered him profoundly dysphonic. Involvement of oropharyngeal muscles resulted in a temporary but distressing maximal protrusion of the tongue with venous congestion, swelling and discomfort. Fortunately his airway was maintained, except perhaps briefly during his panic attack, and intravenous and subsequently oral procyclidine prevented further episodes.

Acute dystonia is a well recognised adverse effect of neuroleptics, and in this case fluoxetine may have exacerbated this effect. Although the possibility of acute dystonia following overdose and its appropriate management is described both in the ABPI data sheet and by the Poisons Bureau, laryngeal dystonia