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Idiopathic genital pain and fluvoxamine

SIR: Idiopathic genital pain in men (prostotadynia) is a puzzling and refractory condition. It has not so far been the subject of rigorous psychiatric assessment and treatment. We attempted to determine which psychological factors were related to a good outcome in a prospective drug-treatment study. Fluvoxamine was chosen because of evidence that reduced levels of central 5-HT could cause chronic pain syndrome (Messing & Lytle, 1977).

In a urology clinic, 50 consecutive patients with idiopathic genital pain were given a psychiatric interview, including pain and psychosexual history, supplemented by the Hospital Anxiety and Depression scale (HAD) (Zigmond & Snaith, 1983) and analogue pain scores. Pain was typically reported as being mainly testicular (42%) or perineal (30%) but radiation to other perigenital sites was common. It was described as aching (46%) or burning (20%) with a mean duration of 5.6 years (range 3 months to 40 years).

Post-ejaculatory exacerbation was reported by 42%, and 90% gained no benefit from analgesics. Aetiological factors included genital surgery (26%), infection (18%), and trauma (19%). The complaints included dyspareunia (26%), premature ejaculation (16%) and erectile impotence (10%). The following DSM–III–R diagnoses were made: major depressive episode in 26%, anxiety disorder in 14%, conversion disorder in 12%, and none in 48%.

In view of the high incidence of depression and poor response to analgesics, an open trial of fluvoxamine was performed in 24 patients. Of these, 12 suffered from affective disorder (major depression 8, anxiety disorder 4) and 12 had no psychiatric disorder. The group with major depression and anxiety after eight weeks showed statistically significant reductions in mean pain scores on an analogue scale (depression mean pain score falling from 5.8 to 2.1, and anxiety from 7.5 to 1.0). In the affective disorder group, both anxiety and depression improved, both on patient report and on the HAD scale. Interestingly, the group with no psychiatric diagnosis did equally well with the mean pain score falling from 6.2 to 2.8 after eight weeks and with no change in anxiety or depression scores (HAD scale). It cannot therefore be claimed that it is simply the treatment of the affective disorder which is giving rise to the analgesic effect in these patients. Patients with sexual dysfunction and voiding disturbances reported concomitant improvement in these symptoms as pain resolved. It would appear that fluvoxamine may have a role in treating this chronic pain syndrome and associated symptoms whether or not there is coexisting affective disorder.

The likely mechanism here is of an increase in pain threshold and inhibition of nociception due to increased spinal 5-HT turnover. 5-HT neurons project from the nucleus raphe magnus to the dorsal horn of the spinal cord. Experimental stimulation of these neurons has been shown to increase the nociceptive threshold and induce analgesia (Fields, 1984). We await further clinical studies to determine whether 5-HT reuptake inhibitors are of value in other chronic pain syndromes.

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'The current literature' – Worcester Development Project

SIR: Although within the Worcester Development Project there has always been a feeling that we got on with the job while others wrote learned dissertations about how it should be done, it must be admitted that published work is somewhat scanty. I was indeed grateful to the Editor for his efforts which ultimately resulted in the book describing the project, published under the Royal College of Psychiatrists' imprint in 1991 (*The Closure of Mental Hospitals*, edited by Peter Hall & Ian F. Brockington).

There have, nevertheless, been a few other publications over the years, for example, an early account by the Unit Manager and myself (Hall & Gillard, 1982), and other valuable articles by non-psychiatrists. These have, for example, included Christine Bennett's (1989) paper; the article by Dr Chris Dowrick *et al* (1980); and by the Worcester

Development Project nurses (Lloyd *et al*, 1977). There has also been a good deal of valuable, if formally unpublished work, for example, (Smith L., 1979: *A Survey of Three Years Operation, Franche Hostel, Kidderminster, Worcestershire*; Hassall, Christine & Cross, K. W., 1979: *Closing a Mental Hospital to Admissions: Predictions and Predicaments* and, perhaps above all, *The Worcester Development Project* 1970, a feasibility study for a multi-reorganisation of mental health services, DHSS, London, HMSO).

As you can imagine, it was with keen interest therefore that I turned to Turner & Roberts', apparently substantive, review (*Journal*, January 1992, **160**, 103–107) to find that they had not mentioned any of these publications but devoted their dissertation to two, admittedly interesting, recent papers in a non-psychiatric journal *Health Trends*.

I trust that readers of the *Journal* will forgive my remarking that it seems tiresome to have such omissions when reviewing a topic where the complete literature is so easily accessible and far from overwhelming.

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A HUNDRED YEARS AGO

Succi's madness

The Italian fasting-man has succumbed to the fate which many of his compatriots anticipated for him – he has lost his reason and is now an inmate of the Asylum of Saint Anne in Paris. It is not so long ago that he was in London repeating, or attempting to repeat, the continuous abstention from food which had procured him such notoriety in Florence and elsewhere. He broke down, it will be remembered, and the failure to accomplish the self-imposed feat preyed on his mind, which, at the best of times, could never be called sound. From London he repaired to Paris, and there, it seems, such mental sanity as he preserved gave way, and, after comporting himself in an obstreperous and even wild manner on the Boulevard des Italiens, he was removed by the Commissary of Police, protesting that he was the "Emperor Caesar". This was on the night of the 29th ult.; but some days before he had been observed by his Parisian neighbours to be dejected, taciturn, and troubled – in the state, in fact, which usually precedes an outburst of mania. At the infirmary of the depot to which he was taken by the Commissary his demeanour became hourly more excited, and he passed the night in a furiously maniacal condition, shouting, gesticulating, and blaspheming in the polyglot dialect of which he is a master. Seen next day at noon by Dr Garnier, he was pronounced to be labouring under the form of mania known as "religious persecution", not actually dangerous to himself or to bystanders, but apt, in all likelihood, to become so. This development of insanity is often a derivative from what Italian alienists classify as "megalomania" – the madness of self-exaltation, of which, in the spring of 1888, when he performed his great fasting feat in Florence, he betrayed the premonitory symptoms. Those who saw him at that time, watched night and day by relays of medical undergraduates in his room attached to the Istituto di Studi Superiori, could not fail to detect the diseased self-importance which characterised his demeanour and conversation, more particularly when he attempted, in the daily ride allowed him under surveillance, to cross the path of Her Majesty Queen Victoria, whose notice he did everything to attract. No doubt the nutrition of his brain was seriously affected by his abstinence from food, and the inhibitory paresis that must in any case have overtaken him was accelerated, if not actually invited, by the practice. We trust his fate will act as a warning to those who would follow in his footsteps, and deter them from a repetition of feats which have long ago yielded whatever scientific fruit they were capable of bringing forth. Certainly, of all the "careers" known to a century prolific in eccentricities the stupidest, if not the ignoblest, is that of the professional fasting-man – earning his bread by refusing to take it!

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