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Triage in emergency psychiatry

Sir: The concept of triage in emergency psychiatry is an interesting one, clearly elucidated by Morrison *et al* (*Psychiatric Bulletin*, July 2000, **24**, 261–264). Their flow chart elegantly illustrates the process by which cases should be allocated for assessment and one would hope that these considerations would be made in all cases as the number of urgent referrals constantly increases.

However, the final tier of the diagram is perhaps unrepresentative of the resources and manpower available in many departments of psychiatry. There may not be a specialist registrar within the unit and clinical assistants are often part-time, or employed for specific sessions such as day hospital or out-patient clinics. This reduces the staff available to the consultant and senior house officer(s) or the 'on-call' senior house officer. I suspect in practice that the majority of general hospital and accident and emergency referrals are in the first instance dealt with by junior staff, as well as a large proportion of urgent general practitioner referrals. Difficulties may be compounded by manpower shortages and reluctance of locum consultant staff to take on urgent work, other than in a supervisory capacity. In addition, there is rarely a good system in place for monitoring the level of, and response to, emergency referrals.

Although with adequate supervision emergency assessments provide an excellent learning experience for trainees, I feel that their role in the triage and assessment of emergency psychiatric referrals should be clarified and the experience of a senior colleague in providing effective triage utilised to the full.

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Detoxification from heroin with buprenorphine

Sir: There are a number of options available for detoxification from heroin, including methadone tapering regimes, dihydrocodeine reduction, lofexidine, and ultra-rapid naltrexone assisted detoxification under general anaesthetic (Sieve-wright, 2000). Buprenorphine has recently been licenced in the UK for the treatment of opiate dependence and offers an alternative method of withdrawal from heroin; it has proven efficacy for out-patient detoxification (O'Connor *et al*, 1997) but

has been little used in the UK. Here we present the results of a pilot study of 30 consecutive out-patient detoxifications with patients who were using low-dose heroin (£20 approximately 0.2 g daily) using buprenorphine with a standard treatment protocol lasting 7 days.

Of the 30 patients who participated in the study, 15 (50%) successfully completed the detoxification programme and 15 (50%) defaulted. Symptom control appears to have been good, with subject showing mild to moderate withdrawal symptoms throughout the detoxification. The consumption of the medication was easily supervised by clinic staff, ensuring good compliance.

This suggests that, for some opiate dependent patients, a standard prescription protocol of buprenorphine can be used effectively for out-patient heroin detoxification with good compliance and good symptom control. However, as of yet there is no evidence to suggest which type of detoxification is the most effective in terms of matching to patient variables, cost, completion rate or symptom control. Leeds Addiction Unit is currently undertaking a randomised control trial of lofexidine *v.* buprenorphine to look at these issues in detail.

O'CONNOR, P. G., CARROL, K. M., SHI, J. M., *et al* (1997) Three methods of opiate detoxification in a primary care setting. *Annals of Internal Medicine*, **127**, 526–530.

SIEVEWRIGHT, N. (1999) *Community Treatment of Drug Misuse: More Than Methadone*. Cambridge: Cambridge University Press.

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Learning disability in psychiatry – the future of services

Sir: I support what O'Dwyer (*Psychiatric Bulletin*, July 2000, **24**, 247–250) describes of her experiences as a consultant psychiatrist in learning disability. Her difficulties were recognised by other psychiatrists in the UK. Of fundamental influence on the workload of community teams in learning disability are the number of independent care homes in a catchment area rather than the size of the general population. Poor training and a high turnover of care staff compound the difficulties inherent in the workload that the psychiatrist and the mental health team can expect.

With the move to 'normalisation' of learning disability services since the closure of the institutions and the 'de-medicalisation' of care, I believe services have been hijacked by well-meaning

professionals and carers who choose not to recognise, or remain ignorant of, mental illness in this group of people. Ultimately they do a disservice to their clients, which in many cases results in eviction from homes because of difficult behaviour or the inappropriate prescription of potent drugs by general practitioners and general psychiatrists.

Unfortunately they too can hold society's prejudice towards the learning disabled and thus further stigmatise their patients.

In planning services, the importance of well-resourced mental health teams in learning disability cannot be ignored because society has a lot to gain from the understanding of mental health issues in learning disability, which has the potential for skills and treatments to be generalised to other groups in the population.

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Serotonin syndrome

Sir: Mir and Taylor's review of serotonin syndrome (*Psychiatric Bulletin*, December 1999, **23**, 742–747) stated that in practice lithium was well tolerated in combination with a selective serotonin reuptake inhibitor (SSRI), but mentioned four individual reports where problems had been experienced. Two of these involved the emergence of serotonin syndrome after the addition of lithium to the treatment regime of a patient already taking an SSRI without side-effects. I would like to add to these a further case seen as an emergency referral to our Affective Disorders Clinic in May 2000.

Mr B is a 53 year old professional white male who has been suffering with recurrent depressive episodes for the last 18 months. He had been treated with various antidepressants during this time. At the time of his urgent referral he had been taking paroxetine 60 mg daily for over 3 months, to which lithium 400 mg daily had been added 2 weeks previously.

On presentation Mr B described profound nausea with the addition of five of Sternbach's diagnostic criteria for serotonin syndrome: agitation, myoclonus, shivering, tremor and incoordination. Serum lithium levels at this time were within normal limits. Lithium was discontinued and the paroxetine was reduced slowly over the next 6 weeks. Within a week Mr B's symptoms had improved and on 3 week review he was symptom-free with regard to the serotonin syndrome.

The above case of serotonin syndrome was attributed to the addition of lithium to the SSRI. This was because he was side-effect-free on treatment with paroxetine and the symptoms developed shortly



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after commencing lithium. The symptoms disappeared after lithium treatment was terminated, despite the continuation of high, but reducing, doses of paroxetine. Muly *et al* (1993) describe a similar case in which lithium was used in addition to fluoxetine. Similar to the case described here, the symptoms resolved by withdrawal of lithium, despite continuation of antidepressant treatment. This can be explained by the hypothesis that lithium acts to enhance serotonergic function as described expansively by Price *et al* (1990) in their review article of a large body of clinical evidence. In conclusion, it is important to remember that, while lithium is generally a well tolerated drug, there have been increasing reports demonstrating that on addition to a stable SSRI regime, mindfulness of the possibility of serotonin syndrome is essential.

MULY, C. E., McDONALD, W., STEFFENS, D., *et al* (1993) Serotonin syndrome produced by a combination of fluoxetine and lithium. *American Journal of Psychiatry*, **150**, 1565.

PRICE, L. H., CHARNEY, D. S., DELGADO, P., *et al* (1990) Lithium and serotonin function: implications for the serotonin hypothesis of depression. *Psychopharmacology*, **100**, 2–12.

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Monitoring of seizures during electroconvulsive therapy by the 'cuff' method is still relevant today

Sir: Jan Wise *et al* (*Psychiatric Bulletin*, August 2000, **24**, 301) suggest that the use of the cuff method to 'observe' absent seizures during electroconvulsive therapy (ECT) should cease. They based their findings on the fact that there were no differences in the duration of seizures in the cuffed arm and the uncuffed arm. One fails to understand how this would happen if they were using an adequate dose of muscle relaxants. The methodology does not describe the nature or dose of neuromuscular blocking agent used. The authors also need to look at the possibility of a type-II error in view of the small number of ECT episodes included in the study.

It is worthwhile pointing out that the cuff method is not used to merely 'observe' absent seizures, but to monitor inadequate seizures as well as to detect status epilepticus, which can prove fatal if undetected. It is true that electroencephalogram (EEG) monitoring remains the standard, but resource implications mean that most centres in this country will have to manage with the cuff method. I was involved in a study where we found a

strong correlation between duration of seizures as measured by the cuff method and by EEG monitoring. Several authors have replicated this finding.

The monitoring of seizures by the cuff method cannot be entirely dismissed and remains relevant to psychiatric practice today because of its cost-effectiveness.

JAN WISE, M. E., MACKIE, F., ZAMAR, A. C., *et al* (2000) Investigation of the 'cuff' method for assessing seizure duration in electroconvulsive therapy. *Psychiatric Bulletin*, **24**, 301.

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Sir: I read with interest the article by Jan Wise *et al* (*Psychiatric Bulletin*, August 2000, **24**, 301). The authors cast doubts about using the Hamilton cuff method for assessing seizure duration and recommended EEG monitoring as a standard procedure need of ECT. EEG seizure monitoring indeed helps to prevent unwarranted restimulation as well as detecting prolonged seizures (Mayur *et al*, 1999), however the use of the cuff technique needs to be viewed in terms of its benefit and risk, especially in places where EEG monitoring is not available. Jan Wise *et al* have not reported the dosage of the muscle relaxants used. For patients who require high dose of succinylcholine, > 1.0 mg/kg, (eg. patients with bone and joint problems who require complete muscle paralysis, or patients who need longer ECT session for stimulus dose titration), seizure could be masked. In addition, the finding that there was no significant difference in seizure duration between cuffed and uncuffed limbs could be limited by a lack of blindness between three observers. All raters were using a similar approach to note the seizure duration at the same time and place.

I have reservation in disregarding the cuff technique and would rather support the College recommendation (Royal College of Psychiatrists, 1995) that cuff duration should be kept to a minimum and the cuff inflation should be released as soon as adequate seizure duration has occurred. Care also needs to be taken for patients with severe osteoporosis, other major orthopaedic problems and sickle cell disease (Weiner *et al*, 1991).

MAYUR, P. M., GANGADHAR, B. N., JANAKIRAMAIAH, N., *et al* (1999) Motor seizure monitoring during electroconvulsive therapy. *British Journal of Psychiatry*, **174**, 270–272.

ROYAL COLLEGE OF PSYCHIATRISTS (1995) *The ECT Handbook. Second Report of the Royal College of Psychiatrists' Special Committee on ECT*. London: Royal College of Psychiatrists.

WEINER, R. D., COFFEY, C. E. & KRISTAL, A. D. (1991) The monitoring and management of electrically induced seizures. *Psychiatric Clinics of North America*, **14**, 845–869.

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Suicide and the internet

Sir: In his paper on the potential influence of the internet on suicide, Thompson (1999) considered the availability of dangerous information and the existence of certain sites advocating suicide. Several cases of completed suicide, using methods described on the internet, have been reported since the first such UK report on the subject in 1998 (Haut). We wish to report a case in which the internet's rapidly developing market-place provided the drug employed in a successful suicide.

The patient, a thirty-four year old male, was admitted after an overdose of clomipramine. This had been obtained from an overseas pharmacy, which sold prescription-only drugs on the internet without the need for a prescription. After discharge, the man took a second and fatal overdose of clomipramine that had been obtained, against our advice, from the same source. We were surprised at the ease with which it is possible to obtain a wide range of prescription-only drugs via the internet. One site, for example, offered a list of overseas pharmacies and included advice on how to avoid legal difficulties in obtaining drugs from them.

The sale of prescription drugs in the UK is controlled by the Medicines Act, but the purchase of such drugs from overseas pharmacies seems to fall into a legal grey area. All that UK authorities can currently do is stop such medications at customs control. It has recently been reported in the press that the Medicines Control Agency and the National Criminal Intelligence Service are starting to work with other countries to develop international standards to control the sale of drugs on the internet.

The internet can provide both the information and the physical means enabling people to commit suicide. We are used to considering our clients' use of illegal substances or legally obtained prescription drugs, but increasingly we may need to be aware of their use of illegally obtained prescription drugs.

HAUT, F. (1998) The Internet and the future of psychiatry (letter). *Psychiatric Bulletin*, **22**, 641–642.

THOMPSON, S. (1999) The Internet and its potential influence on suicide. *Psychiatric Bulletin*, **23**, 449–351.

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