PEARSON, V. (1995) Population poplicy and eugenics in China. *British Journal of Psychiatry*, **167**, 1–4.
UZYCH, L. (1986) Genetic testing and exclusionary practices in the workplace. *Journal of Public Health Policy*, **7**, 37–57.
— (1992) Human genetics, bioethics, and the law. *Journal of the National Cancer Institute*, **84**, 127–128.
— (1995) Genetic testing for children and adolescents. *Journal of the American Medical Association*, **273**, 1089–1090.

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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 Recently valproate, 2500 mg per day, then phenytoin, 200 mg per day, were added and carbamazepine gradually withdrawn.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.

COXHEAD, N., SILVERSTONE, T. & COOKSON, J. (1992) Carbamazepine versus lithium in the prophylaxis of bipolar affective disorder. *Acta Psychiatrica Scandinavica*, **85**, 114–118.
SCHOU, M. (1993) Is there a lithium withdrawal syndrome? An examination of the evidence. *British Journal of Psychiatry*, **163**, 514–518.

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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

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is not recognised unless a high index of suspicion is maintained. Neuroleptic-induced dystonia often may be discounted as odd behaviour caused by psychiatric disorder. Without the characteristic dystonia of larger muscle groups I might also have attributed the dysphonia and choking sensations to anxiety. Given the long half-life of chlorpromazine (and fluoxetine), the patient would have been at risk of further episodes of potentially dangerous laryngeal dystonia. It would be useful for clinicians to be given more explicit advice on the recognition of laryngeal dystonia and the rare possibility of asphyxiation.

DATAPHARM PUBLICATIONS (1995–96) APTI *Data Sheet Compendium* pp. 492–494 and pp. 1386–1388.
THORBURN, R. (1995) Dystonia and neuroleptic medication (Letter). *British Journal of Psychiatry*, **167**, 114.

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Risperidone response after no clozapine response

SIR: Risperidone has been shown to be effective in the treatment of chronic schizophrenia (Ereshefsky *et al*, 1989; Lader, 1992); we wish to report a patient who responded to risperidone but not to clozapine.

X, a 35-year-old man with a 20-year history of schizophrenia, has received most known antipsychotic medications with only partial remissions. He was first hospitalised in December 1993, in a florid psychotic state, showing severe formal thought disorder, flight of ideas, auditory hallucinations and delusions of grandeur. He was given clozapine gradually increasing to 500 mg daily for six months. A deterioration in his mental state necessitated his transfer to a closed ward in April 1994. Treatment with clozapine was immediately stopped, after which he responded only minimally to anti-psychotic medication.

In December 1994 he received risperidone up to 4.5 mg. After 2 weeks of treatment his BPRS score dropped from 45 to 27 (18 items, 1–7 each item) and after 14 weeks his CGI score had improved from 6 to 2. He was transferred to a rehabilitation ward and discharged to his family three and a half months after beginning treatment with risperidone.

It has been reported that a patient responsive to clozapine was reported to be unresponsive to risperidone (Mok & Yatham, 1994). This case report is the first to our knowledge in which the opposite has been shown. As risperidone and clozapine have been shown to be similarly effective in the treatment of schizophrenia (Heinrich *et al*, 1990) we suggest that this report is an indicator that risperidone should be considered in the treatment of drug resistant patients with schizophrenia.

ERESHEFSKY, L., WANATABE, M. D. & TRAN-JOHNSON, T. K. (1989) Clozapine: an atypical antipsychotic agent. *Clinical Pharmacology*, **8**, 691–709.
HEINRICH, K., KLEISER, E., LEHMANN, E., *et al* (1990) Experimental comparison of the efficacy and compatibility of risperidone and clozapine in acute schizophrenia. *17th Congress of Collegian Internationale Neuro-Psychopharmacologicum*, Kyoto, September 1990.
LADER, M. (1992) Clozapine: a summary. *British Journal of Psychiatry*, **160**(suppl. 17), 65–66.
MOK, H. & YATHAM, L. N. (1994) Response to clozapine as a predictor of risperidone response in schizophrenia. *American Journal of Psychiatry*, **151**, 1393–1394.

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