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MARCH 1997 VOL. 170

## EDITORIALS



## PAPERS



## COLUMNS





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# George doesn't know what SSRI means ...

## ... He just knows his doctor made a logical choice



**"... SSRIs deserve consideration as first-line therapy for depression in older patients[1]"**

Lundbeck

Cipramil▼
citalopram
*your partner in depression*

**Presentation:** 'Cipramil' tablets. PL 0458/0058, each containing 20mg of citalopram as the hydrobromide. 28 (OP) 20mg tablets £21.28. **Indications:** Treatment of depressive illness in the initial phase and as maintenance against relapse/recurrence. **Dosage: Adults:** 20mg a day. Depending upon individual patient response, this may be increased in 20mg increments to a maximum of 60mg. Tablets should not be chewed, and should be taken as a single oral daily dose, in the morning or evening without regard for food. **Elderly:** 20mg a day increasing to a maximum of 40mg dependent upon individual patient response. **Children:** Not recommended. Restrict dosage to lower end of range in hepatic impairment. Dosage adjustment not necessary in cases of mild/moderate renal impairment. No information available in severe renal impairment (creatinine clearance <20ml/min). **Contra-indications:** Combined use of 5-HT agonists. Hypersensitivity operating machinery. History of mania. Caution in patients at risk of cardiac arrhythmias. Do not use with or within 14 days of MAO inhibitors: leave a seven day gap before starting MAO inhibitor treatment. **Drug Interactions:** MAO inhibitors (see Precautions). Use lithium and tryptophan with caution. Routine monitoring of lithium levels need not be adjusted. **Adverse Events:** Most commonly nausea, sweating, tremor, somnolence and dry mouth. **Overdosage:** Symptoms have included somnolence, coma, sinus tachycardia, occasional nodal rhythm, episode of grand mal convulsion, nausea, vomiting, sweating and hyperventilation. No specific antidote. Treatment is symptomatic and supportive. Early gastric lavage suggested. **Legal Category:** POM 24.1.95. Further information available upon request. Product licence holder: Lundbeck Ltd., Sunningdale House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LF. 'Cipramil' is a

# THE BRITISH JOURNAL OF PSYCHIATRY

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| Edward H. Hare | 1973–77 | Hugh L. Freeman | 1984–93 |

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# 4TH LATERALITY AND PSYCHOPATHOLOGY CONFERENCE

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**19–21 June 1997**
(reception evening 18 June)

Charing Cross and Westminster Medical School, University of London, United Kingdom

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**World Biological Psychiatry Pre-Congress Event**
in association with
International Organisation of Psychophysiology
Neuropsychobiology Section World Psychiatry

**Abstract and pre-registration deadline: 2 May 1997**

**Further information:** Mrs Maria Ketley, Dept. of Psychiatry, Charing Cross and Westminster Medical School, St Dunstan's Road, London W6 8RP, England.
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# REASON TO BE CHEERFUL

# LUSTRAL™ 50mg

sertraline

**Abbreviated Prescribing Information: LUSTRAL™ (sertraline)**
**Presentation:** Tablets containing 50mg or 100mg sertraline. **Indications:** Treatment of symptoms of depressive illness and accompanying symptoms of anxiety. Prevention of relapse or recurrence of depressive episodes including accompanying symptoms of anxiety. **Dosage:** LUSTRAL should be given as a single daily dose. The initial dose is 50mg and the usual therapeutic dose is 50mg daily. Dosage can be further increased, if appropriate, to 150mg or a maximum of 200mg daily. Patients should be maintained on the lowest effective dose and doses of 150mg or more should not be used for periods exceeding 8 weeks. Use in children: Not recommended. Use in elderly: Lower dose if clearly needed. **Lactation:** Not recommended. **Precautions, warnings:** Renal insufficiency, unstable epilepsy, ECT, driving. LUSTRAL should be discontinued in a patient who develops seizures. LUSTRAL should not be administered to patients concurrently being treated with tranquillizers who drive or operate machinery. Do not use with, or within two weeks of ending treatment with, MAOIs. At least 14 days should elapse before starting any MAOI following discontinuation of LUSTRAL. Patients should be closely supervised for the possibility of suicide attempt or activation of mania/hypomania. **Drug interactions:** Administer with caution in combination with other centrally active medication. Serotonergic drugs including tryptophan, sumatriptan and fenfluramine should not be used with LUSTRAL. It is recommended that plasma lithium levels be monitored following initiation of LUSTRAL. Although LUSTRAL has been shown to have no adverse interaction with alcohol, concomitant use with alcohol is not advised. The potential for LUSTRAL to interact with other highly protein bound drugs should be borne in mind. The potential of LUSTRAL to interact with e.g. warfarin, diazepam, tolbutamide and cimetidine has not been fully assessed. With warfarin prothrombin time should be monitored when LUSTRAL is initiated or stopped. **Side-effects:** Dry mouth, nausea, diarrhoea/loose stools, ejaculatory delay, tremor, increased sweating, dyspepsia, dizziness, insomnia and somnolence. Asymptomatic elevations in serum transaminases have been reported infrequently (approx. 0.8%) in association with LUSTRAL. These usually occurred within the first 9 weeks treatment and resolved on cessation of therapy. Malaise and rash have been reported. Seizures (see precautions, warnings). There have been isolated reports of movement disorders and rare cases of hyponatraemia. **Legal category:** POM. **Basic NHS cost:** 50mg tablet (PL 57/0308) Calendar pack of 28, £26.51; 100mg tablet (PL 57/0309) Calendar pack of 28, £39.77.
Further information on request.
Invicta™ Pharmaceuticals or Richborough™ Pharmaceuticals Divisions of Pfizer Limited, Sandwich, Kent.

CNS DISCOVERY

RICHBOROUGH INVICTA


Adjunctive treatment for partial seizures

**TOPAMAX Abbreviated Prescribing Information. Please read the data sheet before prescribing.**
**Presentation:** Tablets each imprinted "TOP" on one side and strength on the other containing 25mg (white), 50mg (light yellow), 100mg (yellow), and 200mg (salmon) topiramate. **Uses:** Adjunctive therapy of partial seizures, with or without secondarily generalised seizures, in patients inadequately controlled on conventional first line antiepileptic drugs. **Dosage and Administration:** *Adults and Elderly:* Oral administration. Usual dose: 200mg - 600mg/day in two divided doses. Maintenance dose should be reached by titration. See data sheet for titration. Do not break tablets. It is not necessary to monitor topiramate plasma concentrations. Patients with renal disease/haemodialysis may require a modified titration schedule. (See data sheet). *Children:* Not recommended

**Contra-indications:** Hypersensitivity to any component of the product. **Precautions and Warnings:** Withdraw all antiepileptic drugs gradually. Maintain adequate hydration to reduce risk of nephrolithiasis (especially increased in those with a predisposition). Drowsiness likely. TOPAMAX may be more sedating than other antiepileptic drugs therefore caution in patients driving or operating machinery, particularly until patients' experience with the drug is established. Do not use in pregnancy unless potential benefit outweighs risk to foetus. Women of child bearing potential should use adequate contraception. Do not use if breastfeeding. **Interactions:** *Other Antiepileptic Drugs:* No clinically significant effect except in some patients on phenytoin where phenytoin plasma concentrations may increase. Phenytoin level monitoring is advised. *Effects of other antiepileptic drugs:* Phenytoin and carbamazepine decrease topiramate plasma

**CLOZARIL ABBREVIATED PRESCRIBING INFORMATION. The use of CLOZARIL is restricted to patients registered with the CLOZARIL Patient Monitoring Service. Indication**: Treatment-resistant schizophrenia (patients non-responsive to, or intolerant of, conventional neuroleptics). **Presentations** 25 mg and 100 mg clozapine tablets. **Dosage and Administration** Initiation of CLOZARIL treatment must be in hospital in-patients and is restricted to those patients with a normal white blood cell count and differential count. Initially, 12.5 mg once or twice on first day, followed by one or two 25 mg tablets on second day. Increase slowly, initially by daily increments of 25 to 50 mg, followed by increments of 50 to 100 mg to reach a therapeutic dose within the range of 200 to 450 mg daily. The total daily dose should be divided and a larger portion of the dose may be given at night. Once control is achieved a maintenance dose of 150 to 300 mg daily may suffice. At daily doses not exceeding 200mg, a single administration in the evening may be appropriate. Exceptionally, doses up to 900 mg daily may be used. Patients with a history of epilepsy should be closely monitored during CLOZARIL therapy since dose-related convulsions have been reported. Therefore, patients with a history of seizures, as well as those suffering from cardiovascular, renal or hepatic disorders, together with the elderly need lower doses (12.5 mg given once on the first day) and more gradual titration. **Contra-Indications** Hypersensitivity to clozapine. History of drug-induced neutropenia/agranulocytosis, myeloproliferative disorders, uncontrolled epilepsy, alcoholic and toxic psychoses, drug intoxication, comatose conditions, circulatory collapse and/or CNS depression of any cause and severe hepatic, renal or cardiac failure. **Warning** CLOZARIL can cause agranulocytosis. A fatality rate of up to 1 in 300 has been estimated when CLOZARIL was used prior to recognition of this risk. Since that time strict haematological monitoring of patients has been demonstrated to be effective in markedly reducing the risk of fatality. Because of the risk associated with CLOZARIL therapy its use is therefore limited to treatment-resistant schizophrenic patients:- 1. who have normal leucocyte findings (white blood cell count and differential blood count), and 2. in whom regular leucocyte counts can be performed weekly during the first 18 weeks and at least every two weeks thereafter for the first year of therapy. After one years treatment monitoring may be changed to four weekly intervals in patients with stable neutrophil counts. Monitoring must continue as long as treatment continues. Patients must be under specialist supervision and CLOZARIL supply is restricted to hospital and community pharmacies registered with the CLOZARIL Patient Monitoring Service. Prescribing physicians must register themselves, their patients and a nominated pharmacist with the CLOZARIL Patient Monitoring Service. This service provides for the required leucocyte counts as well as a drug supply audit so that CLOZARIL treatment is promptly withdrawn from any patient who develops abnormal leucocyte findings. Each time CLOZARIL is prescribed, patients should be reminded to contact the treating physician immediately if any kind of infection begins to develop. Particular attention should be paid to flu-like complaints or other symptoms which might suggest infection, such as fever or sore throat. **Precautions** CLOZARIL can cause agranulocytosis. Perform pre-treatment white blood cell count and differential count to ensure only patients with normal findings receive CLOZARIL. Monitor white blood cell count weekly for the first 18 weeks and at least two-weekly for the first year of therapy. After one years treatment, monitoring may be changed to four weekly intervals in patients with stable neutrophil counts. Monitoring must continue as long as treatment continues. If the white blood count falls below 3.0 x $10^9$/l and/or the absolute neutrophil count drops below 1.5 x $10^9$/l, withdraw CLOZARIL immediately and monitor the patient closely, paying particular attention to symptoms suggestive of infection. Re-evaluate any patient developing an infection, or with a routine white blood count between 3.0 and 3.5 x $10^9$/l and/or a neutrophil count between 1.5 and 2.0 x $10^9$/l, with a view to discontinuing CLOZARIL. Any further fall in white blood/neutrophil count below 1.0 x $10^9$/l and/or 0.5 x $10^9$/l respectively, after drug withdrawal requires immediate specialised care. Where protective isolation and administration of GM-CSF or G-CSF may be indicated. Colony stimulating factor therapy should be discontinued when the neutrophil count returns above 1.0 x $10^9$/l. CLOZARIL lowers the seizure threshold. Orthostatic hypotension can occur therefore close medical supervision is required during initial dose titration. Monitor hepatic function in liver disease. Use with care in prostatic enlargement, narrow-angle glaucoma and paralytic ileus. Patients affected by the sedative action of CLOZARIL should not drive or operate machinery. CLOZARIL should be administered with caution to patients who participate in activities requiring complete mental alertness. Patients with fever should be carefully evaluated to rule out the possibility of an underlying infection or the development of agranulocytosis. Do not give CLOZARIL with other drugs with a substantial potential to depress bone marrow function. CLOZARIL may enhance the effects of alcohol, MAO inhibitors, CNS depressants and drugs with anticholinergic, hypotensive or respiratory depressant effects. Caution is advised when CLOZARIL therapy is initiated in patients who are receiving (or have recently received) a benzodiazepine or any other psychotropic drug as these patients may have an increased risk of circulatory collapse, which, on rare occasions, can be profound and may lead to cardiac and/or respiratory arrest. Caution is advised with concomitant administration of therapeutic agents which are highly bound to plasma proteins. Clozapine binds to and is partially metabolised by the isoenzyme cytochrome P450 2D6. Caution is advised with drugs which possess affinity for the same isoenzyme. Concomitant cimetidine and high dose CLOZARIL was associated with increased plasma clozapine levels and the occurrence of adverse effects. Discontinuation of concomitant carbamazepine resulted in increased clozapine levels. Phenytoin decreases clozapine levels resulting in reduced effectiveness of CLOZARIL. No clinically relevant interactions noted with antidepressants, phenothiazines and type Ic antiarrhythmics observed, to date. Isolated reports of fluvoxamine increasing clozapine plasma levels by 5-10 fold. Concomitant use of lithium or other CNS-active agents may increase the risk of neuroleptic malignant syndrome. The hypertensive effect of adrenaline and its derivatives may be reversed. Do not use in pregnant or nursing women. Use adequate contraceptive measures in women of child bearing potential. **Side-Effects** Neutropenia leading to agranulocytosis (See Warning and Precautions). Rare reports of leucocytosis including eosinophilia. Isolated cases of leukaemia and thrombocytopenia have been reported but there is no evidence to suggest a causal relationship with the drug. Most commonly fatigue, drowsiness, sedation. Dizziness or headache may also occur. CLOZARIL lowers the seizure threshold and may cause EEG changes and delirium. Myoclonic jerks or convulsions may be precipitated in individuals who have epileptogenic potential but no previous history of epilepsy. Rarely it may cause confusion, restlessness, agitation and delirium. Extrapyramidal symptoms are limited mainly to tremor, akathisia and rigidity. Neuroleptic malignant syndrome has been reported. Transient autonomic effects eg dry mouth, disturbances of accommodation and disturbances in sweating and temperature regulation. Hypersalivation. Tachycardia and postural hypotension, with or without syncope, and less commonly hypertension may occur. In rare cases profound circulatory collapse has occurred. ECG changes, arrhythmias, pericarditis and myocarditis (with or without eosinophilia) have been reported, some of which have been fatal. Isolated cases of respiratory depression or arrest, with or without circulatory collapse. GI disturbances, increases in hepatic enzymes. In rare cases, cholestasis has been reported and very rarely ileus may occur. Rarely aspiration may occur in patients presenting with dysphagia or as a consequence of acute overdosage. Both urinary incontinence and retention and priapism have been reported. Benign hyperthermia may occur and isolated reports of skin reactions have been received. Rarely, hyperglycaemia has been reported. Rarely increases in CPK values have occurred. With prolonged treatment considerable weight gain has been observed. Sudden unexplained deaths have been reported in patients receiving CLOZARIL. **Package Quantities and Price** Community pharmacies only. 28 x 25mg tablets: £12.52 (Basic NHS) 28 x 100mg tablets: £50.05 (Basic NHS). Hospital pharmacies only. 84 x 25 mg tablets: £37.54 (Basic NHS). 84 x 100 mg tablets: £150.15 (Basic NHS). Supply of CLOZARIL is restricted to hospital and community pharmacies registered with the CLOZARIL Patient Monitoring Service. **Product Licence Numbers** 25 mg tablets: PL 0101/0228. 100 mg tablets: PL 0101/0229. **Legal Category** POM. CLOZARIL is a registered Trade Mark. **Date of preparation** January 1996. Full prescribing information, including Product Data Sheet is available from SANDOZ PHARMACEUTICALS. Frimley Business Park, Frimley, Camberley, Surrey, GU16 5SG.

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*promise to put patients' lives back the way they were. But the right choice of medication may help them find a place in their community.*

*Zyprexa demonstrated improvement in the negative as well as the positive symptoms of schizophrenia (in four out of five controlled trials in patients presenting with both positive and negative symptoms).*[1-3]

*With a simple once-daily dosage and no requirement for routine blood or ECG monitoring,*[4] *Zyprexa may offer a step towards community re-integration.*

**Antipsychotic Efficacy for First-line Use**

**Zyprexa**
Olanzapine

**Making Community Re-integration the Goal**

Caution in patients who have a history of seizures or have conditions associated with seizures. If signs or symptoms of tardive dyskinesia appear a dose reduction or drug discontinuation should be considered. Caution when taken in combination with other centrally acting drugs and alcohol. Olanzapine may antagonise the effects of direct and indirect dopamine agonists. Postural hypotension was infrequently observed in the elderly. However, blood pressure should be measured periodically in patients over 65 years, as with other antipsychotics. As with other antipsychotics, caution when prescribed with drugs known to increase QTc interval, especially in the elderly. In clinical trials, olanzapine was not associated with a persistent increase in absolute QT intervals. **Interactions:** Metabolism may be induced by concomitant smoking or carbamazepine therapy. **Pregnancy and Lactation:** Olanzapine had no [illegible] should be used in pregnancy only if the potential benefit justifies the potential risk to the foetus. Olanzapine was excreted in the milk of treated rats but it is not known if it is excreted in human milk. Patients should be advised not to breast feed an infant if they are taking olanzapine. **Driving, etc:** Because olanzapine may cause somnolence, patients should be cautioned about operating hazardous machinery, including motor vehicles. **Undesirable Effects:** The only frequent (>10%) undesirable effects associated with the use of olanzapine in clinical trials were somnolence and weight gain. Occasional undesirable effects included dizziness, increased appetite, peripheral oedema, orthostatic hypotension, and mild, transient anticholinergic effects, including constipation and dry mouth. Transient, asymptomatic elevations of hepatic transaminases, ALT, AST have been seen occasionally. Olanzapine-treated patients had a lower incidence of Parkinsonism, akathisia and dystonia in trials compared with [illegible]peridol. Photosensitivity reaction or high creatinine phosphokinase were reported rarely. Plasma prolactin levels were sometimes elevated, but associated clinical manifestations were rare. Asymptomatic haematological variations were occasionally seen in trials. *For further information see summary of product characteristics.* **Legal Category:** POM. **Marketing Authorisation Numbers:** EU/1/96/022/004 EU/1/96/022/006 EU/1/96/022/009 EU/1/96/022/010. **Basic NHS Cost:** £52.73 per pack of 28 x 5mg tablets. £105.47 per pack of 28 x 10mg tablets. £158.20 per pack of 56 x 7.5mg tablets. £210.93 per pack of 56 x 10mg tablets. **Date of Preparation:** August 1996. **Full Prescribing Information is Available From:** Lilly Industries Limited, Dextra Court, Chapel Hill, Basingstoke, Hampshire RG21 5SY. Telephone: Basingstoke (01256) 315000. 'ZYPREXA' is a Lilly trademark.

References: 1. Data on file, Lilly Industries. 2. Data on file, Lilly Industries. 3. Zyprexa Summary of Product Characteristics, Section 5.1: Pharmacodynamic Properties. 4. Zyprexa Summary of Product Characteristics.

NATIONAL CONFERENCE

1 MAY 1997
AT YORK RACECOURSE

# MENTAL HEALTH "A POSITIVE FUTURE?"

A major Conference, suitable for innovative professionals with an interest in the future of Mental Health, jointly organised by Northallerton Health Services (NHS) Trust and Craegmorr Healthcare.

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Professor Keith Cash, *Leeds Met. University*
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Jim McImoggert, *St Andrews, Northampton*
Dr C. J. Simpson, *Psychiatrist, Northallerton*
Dr H. G. Daudjee, *Psychiatrist, Bradford*
Dr V. Cox, *General Practitioner, Catterick*

CPD accreditation for Psychiatrists had been applied for; One full day PGEA accreditation for GPs has already been granted.

Conference costs £95 + VAT prior to 1.4.97 (£120 + VAT after 1.4.97) and includes: Exhibition, 14 concurrent sessions, Lunch and refreshments.

Further details together with booking form are available from:

Janis Bottomley
Department of Mental Health
Friarage Hospital
Northallerton
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# Patient with schizophrenia exercises *self* control by shouting at people

The SDA effect of Risperdal can mean a huge difference to the lives of patients with schizophrenia.

Because SDA is the action of Serotonin and Dopamine Antagonism in a single drug. In positive and negative symptoms. In first episode and acute presentations, and in chronic patients. Risperdal continues to provide this SDA effect to give high efficacy, with low levels of extrapyramidal side-effects, to more and more patients.

Helping them keep out of hospitals while enhancing their appreciation of, and participation in, community and family life.

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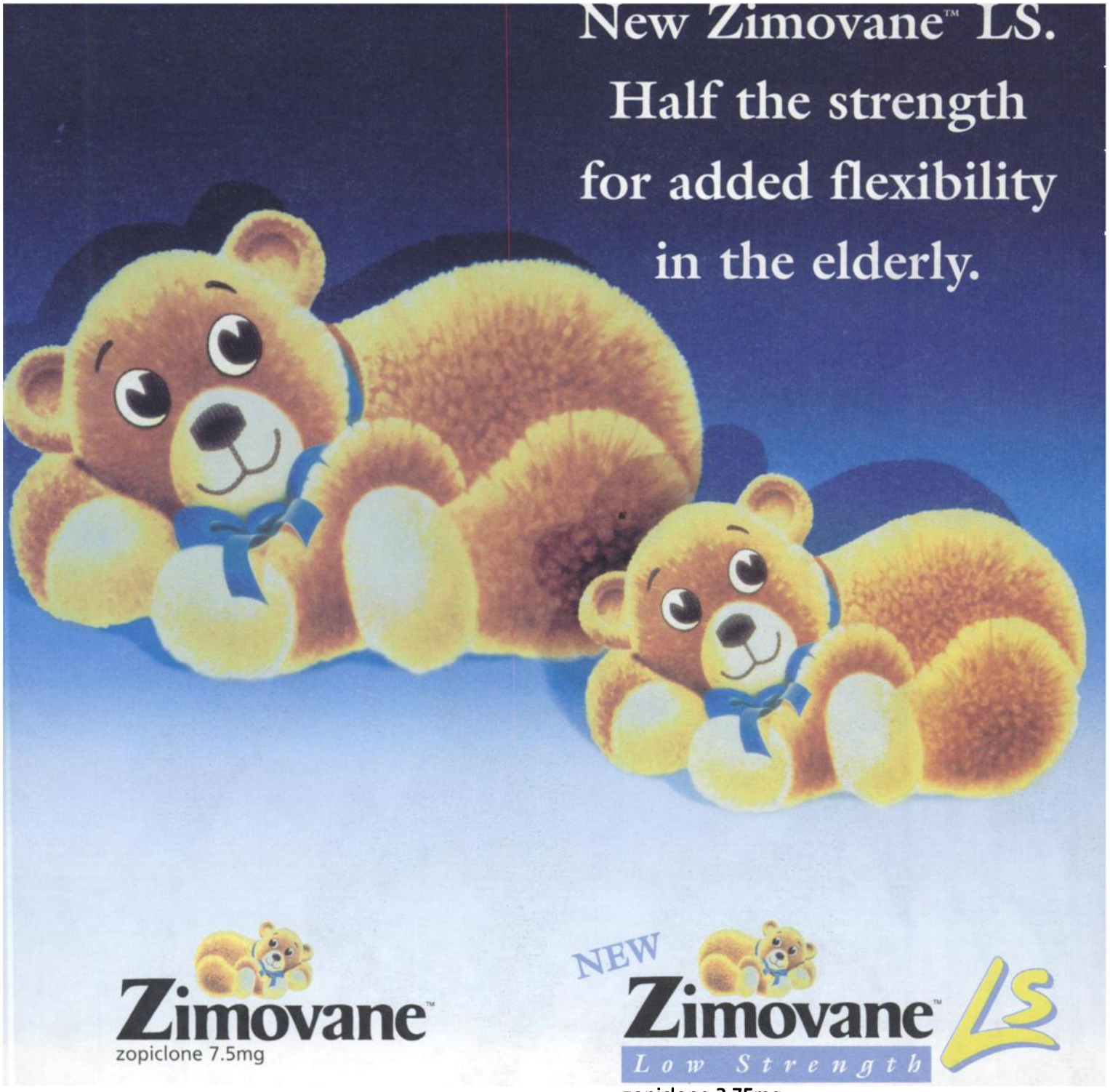


# A non-benzodiazepine that's just right for the elderly.

**Presentation:** Zimovane™: white film coated tablets containing 7.5mg zopiclone. Zimovane™ LS: blue film coated tablets containing 3.75mg zopiclone. The tablets also contain lactose, cellulose and sodium. **Pharmacology:** Zopiclone is a non-benzodiazepine hypnotic, a member of the cyclopyrrolone group of compounds which is structurally unrelated to existing hypnotics and tranquillisers. **Indications:** Short term treatment of insomnia which is debilitating or causing severe distress for the patient. A course of treatment should not be longer than 4 weeks. **Dosage and Administration:** Adults: One 7.5mg tablet shortly before retiring. Elderly and renally impaired: A lower dose of 3.75mg zopiclone is recommended initially. The dosage subsequently may be increased to 7.5mg if clinically necessary. Hepatic insufficiency: A lower dose of 3.75mg is recommended. **Contra-indications:** Myasthenia gravis, respiratory failure, severe sleep apnoea syndrome, severe hepatic insufficiency, hypersensitivity to zopiclone. As with all hypnotics zopiclone should not be used in children. **Precautions:** Zopiclone is not a treatment for depression. Hepatic or renal insufficiency: A lower dose of 3.75mg zopiclone is recommended. **Pregnancy and lactation:** Use of zopiclone is not recommended. **Risk of dependence:** Minimal risk if treatment limited to not more than 4 weeks. Risk may be increased in those who abuse drugs or alcohol, or who have marked personality disorders. **Withdrawal:** Withdrawal effects are unlikely although all patients should be monitored. **Interactions:** Alcohol, CNS depressant, tricyclic antidepressants. **Adverse Effects:** Most frequently, mild bitter or metallic after-taste, mild gastrointestinal disturbances. Occasionally drowsiness on waking, dizziness, light-headedness and incoordination. Although residual effects are rare, patients should not drive or operate machinery until it is established that performance is unimpaired. Psychological and behavioural disturbances and allergic manifestations such as urticaria or rash have been reported. Rebound insomnia on discontinuation of treatment and anterograde amnesia should not be excluded. **Legal Category:** POM. **Pharmaceutical Precautions:** Protect from light. Store in a dry place below 30°C. **Presentation and Basic NHS Cost:** Zimovane™ tablets: PL12/0259; 28 x 7.5mg tablets Basic NHS cost: £4.48. Zimovane™ LS: PL12/0260; 28 x 3.75mg tablets Basic NHS cost: £3.08. **Date of Preparation:** July 1996. Further information is available on request from Rhône-Poulenc Rorer, RPR House, St Leonards Road, Eastbourne, East Sussex BN21 3YG. ZIM 9896

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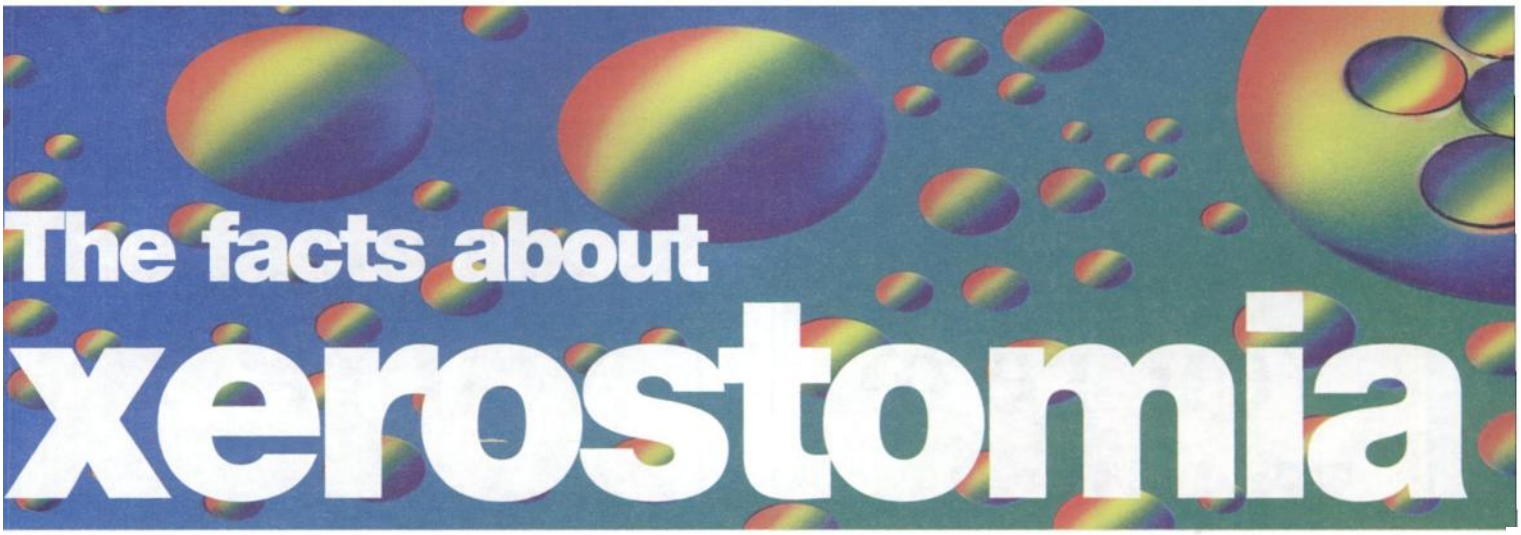
RHÔNE-POULENC RORER




# and how extra saliva can help.

**How big a problem is xerostomia?** Over 10 million people in the UK suffer from a sensation of dry mouth (xerostomia),[1] the subjective report of oral dryness.

The use of medications is one of the most common causes of xerostomia.[2] Over 400 commonly used drugs have been implicated in its aetiology.[2] These include antidepressants, antihistamines, antihypertensives, antipsychotics, antiemetics, anticholinergics, decongestants, diuretics and other blood pressure drugs.[2]

Dry mouth is also associated with Rheumatoid Arthritis, Systemic Lupus Erythematosis, Diabetes, Sjögren's Syndrome, Parkinson's Disease and HIV/AIDS.[2]

**Oral dryness and quality of life** Xerostomics commonly suffer from caries and oral soft tissue irritation, resulting in soreness and painful inflammation within the oral cavity.[3] Dry mouth sufferers are more susceptible to bacteria and yeast infections (candidiasis).[2] Diminished salivary flow results in problems with tasting, chewing and swallowing food.[2] Mouth malodour (halitosis) is a common symptom. Speaking is also uncomfortable and inhibited.[2] Individuals who suffer with dry mouth experience both psychological distress and social embarrassment.

**What to look out for: clinical signs and symptoms**

- Cracked and fissured tongue.
- Frothy saliva and oral mucosa appears pale, thin and has lost its shine.
- A sudden increase in dental caries.
- No pooling of saliva in the floor of the mouth.
- Recurrent oral candida infections.
- A tongue blade or instrument sticking to soft tissues.
- Angular cheilosis.

**Use of sugarfree gum to stimulate saliva** Saliva is a protectant against plaque acid attack,[4] tooth demineralisation,[5] periodontal gingival disease and oral infections.[6]

Recently, considerable success has been achieved in the use of sugarfree gum to relieve the symptoms of xerostomia by stimulating salivary flow.[3,7,8] Research among xerostomia patients has shown chewing gum stimulates saliva by up to 7 times its normal flow rate relative to resting saliva, providing immediate relief.[9] Several studies have also shown that frequent chewing of sugarfree gum has a residual effect on salivary flow even when gum is no longer chewed.[3]

**Sugarfree gum for symptomatic relief** Xerostomia is likely to become more widespread and take on increasing significance as our population becomes older and more reliant on medications. Sugarfree gum provides simple and effective relief from this common and often debilitating condition.

Please send me more information about the diagnosis and relief of xerostomia.

Name: _____ Title: _____

Address: _____

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