

Both patients developed complete dysphagia and reduced gag reflexes prior to the administration of medication for NMS, followed by the development of right lower zone pneumonia, probably due to aspiration. Dantrolene and lorazepam have muscle relaxing properties, and bromocriptine has been associated with reflux oesophagitis (Katzung, 1989). They could have slowed the recovery of the swallowing reflex and worsened aspiration. The first patient received cisapride, a pro-kinetic agent (Walker, 1994), which seemed to be associated with the return of bowel sounds although no improvement in swallowing occurred. Patients who develop NMS should have their gag reflex assessed early and if reduced or absent a nasogastric tube would be recommended to reduce the risk of aspiration.

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#### Clozapine-induced neutropenia – or not

SIR: We wish to bring attention to a point of concern between clinicians and the Clozapine Patient Monitoring Service (CPMS), which may increasingly become an issue as more patients receive clozapine.

Because of the danger of neutropenia (3%; Veys, 1993) and its potentially fatal sequelae, it is absolutely right that regular blood counts be taken.

However, we have had experience of two patients whose survival prospects (through lower suicide risk) and quality of life were radically improved by clozapine. Despite suffering from severe schizophrenic illness unresponsive to conventional neuroleptics, they were able to be discharged from hospital. Both, unfortunately, then had one

abnormal 'red alert' result. Because of the inevitable delay between blood sampling and the results, both patients had continued to take clozapine until the request for the emergency sample was made. In both cases these repeat samples taken 24 h after the 'red alert' sample showed a near doubling of the neutrophil count, with values well into the normal range.

It is known that neutrophil counts vary according to such factors as time of day, physical activity and presence of viral illness (Lewis, 1974). We understand the caution of the pharmaceutical company and the conditions of its licensing agreement, but is it not possible that one isolated result may be due to factors other than clozapine?

We do not question that patients who have had a true clozapine-induced neutropenia should not be rechallenged with the drug (Safferman *et al*, 1992), but we have seen the tragic consequences of stopping clozapine. Is it not over-reacting to stop clozapine on the basis of one blood result, considering the impact on the lives of patients denied its benefits?

As clinicians, in consultation with the patient, relatives and multi-professional team, we would be prepared to take the risk of continuing clozapine in these cases, but we are not permitted to do so. Would it not be possible to amend the regulations so that there must be two consecutive 'red alert' results in 24 h before clozapine is stopped?

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#### Administrative problems limiting electroconvulsive therapy

SIR: In the case report of NMS with prolonged hospitalisation, tracheostomy, intubation, and artificial ventilation (*BJP*, January 1994, **164**, 120-122), Cape notes that the patient "also had one