SSRI and sympathomimetic interaction

SIR: Barrett *et al* (1996) describe two cases of toxicity associated with the combined use of fluoxetine and amphetamine. In both cases, the patients were established on fluoxetine, and had taken only 1 or 2 doses of amphetamine before the acute onset of symptoms associated with psychostimulant overdose or toxicity. Both patients had previously used amphetamine alone, apparently without the development of these symptoms.

One mechanism to account for these cases is a pharmacokinetic interaction between fluoxetine and amphetamine. Amphetamine is metabolised in part by cytochrome P450 2D6 (CYP2D6; Law & Moody, 1994), and fluoxetine is an extremely potent inhibitor of this enzyme (Crewe *et al*, 1992). Evidence to support an interaction could be obtained by examining the ratio of amphetamine to its 4-hydroxy metabolite in such cases (it should be increased).

Clinically, one might question the need to use antidepressants in drug-abusing patients, because of concerns over abuse or safety. However, if the use of an SSRI is unavoidable, this interaction could be minimised or avoided by the use of compounds with less potent CYP2D6 inhibitory activity than fluoxetine, such as citalopram or fluvoxamine (Crewe *et al*, 1992).

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'Psychopaths' in special hospitals

SIR: The article on Young 'Psychopaths' in special hospitals (Reiss *et al*, 1996) outlined how an adverse prognostic factor was that of a previous history of sex offending or offending motivated by sexual factors. The study illustrated however that in practice some young 'psychopaths' have a successful treatment outcome. A minority however after discharge committed further serious offences including homicide. Their article is welcome in the context of the pervasive pessimism that is felt about the treatment of 'psychopaths' within general psychiatry and by a sizeable proportion of forensic psychiatrists (Cope, 1993). The subconscious if not conscious rejection of those designated as psychopaths is in my view not only determined by a debate about treatability but also by artificial boundaries on the definition of mental disorder. Pregnancy may not be a disease but it does frequently require clinical management. Psychopaths may not always be mentally ill in the sense of being deluded, hallucinated or in an abnormal mood state, but their psychological processes are abnormal. Indeed they can be distinguished even within a prison setting (Gunn *et al*, 1991). The co-existence in patients with personality disorder of concurrent episodes of depression, psychosis or brain damage is a familiar clinical finding in both male and female 'psychopaths'.

I personally remain unashamed of retaining the view that, subject to appropriate assessment, some of those with "psychopathic disorder" gain benefit from assessment and treatment in Special Hospitals, although the environment must be therapeutically constructed to maximise personal responsibility of patients while minimising the risk of dangerous behaviour.

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Use of vecuronium to prevent suxamethonium-induced myalgia after ECT

SIR: Muscle pains are a well documented adverse effect of ECT and are generally attributed to the use of depolarising muscle relaxants. The reported incidence of postoperative muscle pain following suxamethonium administration varies as widely as 1.5% to 85% (Magee & Robinson, 1987). Although the aetiology of suxamethonium induced myalgia is unclear, several forms of pretreatment successfully reduce the incidence of this adverse effect. The commonest is pretreatment with a small dose of a non-depolarising muscle relaxant such as vecuronium before induction of anaesthesia. Possible complications of this technique include transient diplopia, difficulties with tracheal intubation and prolonged muscle relaxation. An increased dose of suxamethonium may be required to achieve