smoking clearly represents a huge financial burden on patients with schizophrenia. Money spent on cigarettes is not being spent on clothing, leisure pursuits and personal possessions, which could help to increase the quality of life of these patients. Smoking may be intimately associated with pathophysiological aspects of schizophrenia and further research should be done to clarify the relationship between nicotine consumption and the neurochemistry of schizophrenia. However, health care professionals should be aware of the extent of the financial disadvantage associated with this habit in order to help those patients who might wish to quit through encouragement and support and through prescription of nicotine supplementation where appropriate.

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Imaginal exposure or cognitive therapy in the treatment of post-traumatic stress disorder

Tarrier *et al* (1999) report no significant difference in outcome for patients with post-traumatic stress disorder who received either imaginal exposure or cognitive therapy. They conclude that "clinical benefits for both treatments were maintained".

In the absence of a control group such a conclusion is not warranted. Their findings are open to a number of interpretations, including significant improvement in spite of harmful effects of either or both treatments – supposing, that is, that there were two treatments. Meanwhile, their suggestion that more research is needed does merit support.

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Induction of manic symptoms by novel antipsychotics

There have been scattered reports of mild states of agitation induced by novel antipsychotic agents, in particular disturbed affect during a switch study of risperidone (Ashleigh & Larsen, 1998) and doubtless other cases which have never been reported. At least 19 cases have been reported of risperidone-induced mania (Lane *et al*, 1998; Zolezzi & Badr, 1999). Fitzgerald *et al* (1999) reported a case of olanzapine-induced mania and state that only one similar report existed previously. A Medline search revealed six other cases in the past five years (further details available from the author upon request) and to this series we now add an eighth.

A 55-year-old woman with a 20-year history of chronic anxiety and recurrent depressive episodes developed subjective excitement, increased psychomotor activity, insomnia, irritability and racing thoughts within three days of being prescribed olanzapine 2.5 mg nocte. Her condition rapidly normalised on cessation of olanzapine. There were no features suggestive of akathisia. It should be noted that this case may be slightly weakened by a previous manic episode some 20 years previously.

There have been a small number of reports to the manufacturers' adverse-events database (manufacturers' personal communications) for sertindole, quetiapine and amisulpride where the induction of manic-type symptoms following commencement of the drugs has been a possibility but direct causal effect could not be established with certainty. No such reports could be found in the literature or by application to the manufacturers in respect of clozapine. Clozapine has been cited as having mood-stabilising properties in bipolar affective states (Suppes *et al*, 1999).

The attribution of manicogenic properties to risperidone, olanzapine, sertindole, quetiapine and amisulpride suggests some shared pharmacological characteristics between these agents and most antidepressants, although amisulpride does not bind to serotonin receptors. We conclude that states of agitation, sometimes severe enough to resemble mania, although infrequent, may be a complication of some, if not all, novel antipsychotic agents with the possible exception of clozapine.

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