Correspondence

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Antidepressant withdrawal syndrome

Sir: Pacheco *et al* (1996) report five more cases of paroxetine withdrawal and highlight the general phenomenon of a withdrawal syndrome associated with selective serotonin reuptake inhibitors (SSRIs). A withdrawal syndrome has been reported with all major classes of antidepressants. Indeed, the incidence of the antidepressant withdrawal syndrome following discontinuation of imipramine has been estimated to be from 21% to as high as 100% (Lejoyeux *et al*, 1996) and with monoamine oxidase inhibitors to be 32% (Tyrer, 1984). A withdrawal syndrome has been reported with all of the SSRIs; however, to date, the majority of reports have concerned paroxetine (see Table 1).

Despite the greater incidence of reports concerning paroxetine it is, in the absence of comparative placebo-controlled trials, impossible to determine definitively which antidepressant is more likely to provoke this syndrome. However, in a recent study which incorporated a terminal placebo-controlled discontinuation phase, 34.5% of the group who had previously received paroxetine reported an adverse event on discontinuation compared with 13.5% of patients who had previously received placebo (Oehrberg *et al*, 1995). Paroxetine may be more likely to provoke antidepressant withdrawal because of a combination of a relatively short half-life and more potent anticholinergic effects. However, it remains important to be aware of this phenomenon with all antidepressants, and the gradual dosage reduction advocated by Pacheco *et al* may need to be widely applied to those antidepressants which have relatively short half-lives.

In view of the belief widely held by patients that antidepressants are addictive, it is important to reassure patients that these drugs do not produce tolerance and drug dependence like the benzodiazepines do.

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Table 1 Plasma elimination half-lives, Committee on the Safety of Medicines (CSM) reports of withdrawal reactions, and withdrawal reactions per million prescriptions for serotonin specific reuptake inhibitors (SSRIs)[1]

SSRI	Half-life (active metabolite)	CSM reports of withdrawal reactions	Withdrawal reports/ million prescriptions[2]
Citalopram	36 hours	2	143.9
Fluoxetine	2–3 days (7–15 days)	36	13.3
Fluvoxamine	15 hours	12	21.02
Paroxetine	20 hours	679	237.78
Sertraline	26 hours (36 hours)	44	35.22

1. Information supplied by NHS Executive Northern and Yorkshire Regional Drug and Therapeutics Centre.
2. These figures are approximations based on fees and on a sample of 1 in 200 prescriptions (1989–1990). Data from 1991 onwards cover all prescriptions dispensed by community pharmacists, appliance contractors, dispensing doctors and prescriptions submitted by prescribing doctors for items personally administered.

Graded dosage calendar packs for psychiatric medication

Sir: I wish to urge the pharmaceutical industry to introduce graded dosage calendar packs for psychiatric medication requiring staged changes in dose, and for psychiatric drugs which are often prescribed in subtherapeutic doses by general practitioners and inexperienced junior doctors.

Suitable drugs would thus include tricyclic and certain other antidepressants, some newer antipsychotics, carbamazepine and reducing-dose chlordiazepoxide for alcohol detoxification. Accurate compliance would be easier for patients, particularly those with impaired concentration, memory or motivation. Effective and continued treatment would be encouraged and make unnecessary discontinuation less likely. The complexity and costs of prescription and dispensing would thus be minimised.

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Recent registration and referrals from general practitioners

Sir: We noted that an explicit reason for referral from general practitioners (GPs) to the out-patient clinic may be that the patient is newly registered or not well known to the GP; increasingly, we gained the impression that patients who had recently registered with the GP were over-represented among those referred to our outreach clinic.

Our general adult psychiatric out-patient clinic for patients aged between 20 and 64 years served North-East Edinburgh. The time between registration and the date of the referral letter was established in 50 consecutive non-urgent new referrals, that is, those who had never before been seen by the psychiatric service in Edinburgh (21 patients) or those who had been re-referred after a gap of six months or more (29 patients). The sample consisted of 28 women (mean age 36 years) and 22 men (mean age 36 years) who had been referred by 31 GPs from 15 general practices.

Nine patients (18%) had been registered for one month or less, four (8%) for between one and three months, five (10%) for 3–12 months and 32 (64%) for 12 months or more. The general practice medical records were not available at the time of referral for any of the patients who

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had been registered for less than three months. The medical records were available for four of the patients registered for 3–12 months and for all the patients registered 12 months or more. Thus, one-quarter (95% CI 14–38%) of non-urgent new referrals to a psychiatric outreach clinic had been registered with their GP for less than three months and in no case were the general practice medical records available.

This finding suggested that any association was as likely to be with the lack of medical records as with new registration. In routine cases it takes 8–12 weeks for the new GP to obtain the medical records and this is, on average, four weeks longer when the patient was originally registered outside the Lothians (Primary Care Medical Records, Lothian Health). Most of the delay is accounted for by the time it takes the previous general practice to send the medical records to the new health board.

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Lipid-lowering drugs and mortality

Sir: In their review paper, Boston *et al* (1996) reported that increased mortality with cholesterol lowering has been associated with drugs that do not cross the blood/brain barrier, such as cholestyramine, and those that do, such as statins. However, concern about lipid lowering was prompted by studies of drugs other than statins, namely gemfibrozil and cholestyramine (McLoughlin & Clarke, 1989) and there is evidence that statins are safer. In the West of Scotland Coronary Prevention Study of men with high plasma cholesterol but no history of myocardial infarction, pravastatin reduced the risk of coronary events and the associated deaths without increasing the risk of death from non-cardiovascular causes (Shepherd *et al*, 1995). In a study of myocardial infarction patients who did not have high cholesterol levels, pravastatin reduced non-fatal coronary events with no significant differences in overall mortality or non-cardiovascular mortality (Sacks *et al*, 1996). In the Scandinavian Simvastatin Survival Study there was a significant reduction in risk of death in the simvastatin group in patients with a previous history of coronary artery disease, an effect apparently independent of baseline serum cholesterol (Scandinavian Simvastatin Survival Study Group, 1995). Further evidence for the safety of statins comes from Wardle *et al* (1996) who found no changes in tension, anxiety, anger, hostility or depression in patients taking simvastatin compared with those on placebo. The beneficial effects of statins may be due to actions other than cholesterol lowering and the lack of effect on non-cardiac mortality, which contrasts with gemfibrozil and cholestyramine, may also be independent of cholesterol lowering.

There is unlikely to be any ethical way in which to study in humans what other biochemical factors may be altered by the different groups of lipid-lowering drugs. Raised cholesterol concentrations in adults are related to indices of impaired growth during late gestation (Barker *et al*, 1993) while suicide has been linked with low weight gain in infancy (Barker *et al*, 1995). Attempts to define biochemical variables associated with violence (including suicide) in adulthood may thus be complicated by an interaction with early nutrition.

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Perpetrators of child sexual abuse

Sir: We wish to challenge the unreferenced statement by Hilton & Mezey (1996) that the most common form of sexual abuse is father–daughter incest. Data published recently from our community study of adult New Zealand women showed that when 251 women reported child sexual abuse (CSA) of all types occurring when they were under 16 years of age, 22 recalled the perpetrator to be a father or father figure (i.e. stepfather, adoptive father or mother's live-in boyfriend), 75 recalled other relatives (of whom 21 were brothers), 116 acquaintances of the family and 38 strangers unknown to the girl (Romans *et al*, 1996). When accounts of CSA were restricted to those which involved contact with the girl's genitalia, the perpetrators included 22 father figures, 62 other relatives, 31 family acquaintances and 15 strangers. A similar profile was found for all CSA occurring when the victim was aged 12 years and under: the reported perpetrators included 17 fathers/father figures (12 biological fathers and five stepfathers), 69 other male relatives (of whom 16 were brothers) 81 acquaintances of the family and 26 strangers (unpublished data).

We are not the first group studying CSA to report such a pattern of perpetrator identity. Wyatt (1985) reported the following perpetrator percentages among 158 White American women: father/father figure 6%, other relatives 13% (of whom brothers comprised 3%), family acquaintances 30% and strangers 51%. The equivalent figures for the 147 African–American women in that study were father/father figure 10%, other relatives 19% (of whom brothers comprised 3%), family acquaintances 34% and strangers 37%.

All studies, of which we are aware, reporting a random community design, show substantial numbers of non-father relatives and friends or acquaintances of the victim's family to be perpetrators. Reliance cannot be placed on official judicial, health or welfare figures because of the now well-documented low rates of reporting. The large and important perpetrator categories of non-father biological relatives and family acquaintances need to be considered as they usually account numerically for more CSA than father figures, and the CSA they inflict can be intrusive and repeated (Romans *et al*, 1996).

We believe that it is important to correct this common misconception for at least two reasons. It may produce unwarranted scepticism by the clinician when dealing with

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