THE BRITISH JOURNAL OF PSYCHIATRY

APRIL 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]"

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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 to citalopram. **Pregnancy and Lactation:** Safety during human pregnancy and lactation has not 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 trademark. ©1996 Lundbeck Ltd. Date of preparation: Septem[illegible]

THE BRITISH JOURNAL OF PSYCHIATRY

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Eliot Slater	1961–72	John L. Crammer	1978–83
Edward H. Hare	1973–77	Hugh L. Freeman	1984–93

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Books Beyond Words

These books are joint publications between the Royal College of Psychiatrists and St. George's Hospital Medical School. They are intended for people with learning disabilities or difficulties or mental health needs. The stories are told through pictures alone to allow each reader to make his or her own interpretation. A short written text at the end of the book provides one possible narrative for the pictures. *Gaskell books are available from the Publications Department, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. (Tel. +44(0)171 235 2351, extension 146). Credit card orders can be taken over the telephone.*

You're under Arrest

By Sheila Hollins, Isabel Clare and Glynis Murphy
Illustrated by Beth Webb

The pictures and text in this book are intended to reflect the procedures used by the police when an adult with learning disabilities or mental health needs is under arrest. You can make any story you like from the book as it will fit any crime.

£10.00 72pp. 1996 ISBN 1 901242 01 3

You're on Trial

By Sheila Hollins, Isabel Clare and Glynis Murphy
Illustrated by Beth Webb

The pictures and text in this book are intended to show the likely events when someone with learning disabilities or mental health needs comes into contact with the criminal justice system. The pictures suit any crime and any verdict.

£10.00 72pp. 1996 ISBN 901242 01 3

Going to Court

By Sheila Hollins with Valerie Sinason and Julie Boniface
Illustrated by Beth Webb

This book is about being a witness in a Crown Court. The pictures suit any crime and any verdict.

£10.00 70pp. 1994 ISBN 1 874439 08 7

Jenny Speaks Out

£10.00 60pp. 1992 ISBN 1 874439 001

Bob Tells All

£10.00 62pp. 1993 ISBN 1 874439 03 6
By Sheila Hollins and Valerie Sinason
Illustrated by Beth Webb

These two companion books may enable a person with learning disabilities to open up about their experience of sexual abuse. Bob and Jenny have been abused and feel unsettled when they move to a new homes in the community. In each story, the carers sensitively help Bob and Jenny unravel their painful past as victims of sexual abuse, to begin a slow but positive healing process.

Making Friends

£10.00 68pp. 1995 ISBN 1 874439 10 9

Hug Me Touch Me

£10.00 70pp. 1994 ISBN 1 874439 05 2
By Sheila Hollins and Terry Roth
Illustrated by Beth Webb

The characters in these stories want to make new friends. The books show when they can and can't hug and touch other people. *Making Friends* tells the story from a man's perspective, while *Hug Me Touch Me* tells the story from a woman's point of view.

GASKELL

Going to the Doctor

By Sheila Hollins, Jane Bernal and Matthew Gregory
Illustrated by Beth Webb

Going to the doctor can be a worrying experience. For people with a learning disability, there is the added fear of not being able to explain what's wrong, as well as not understanding what's happening. Feelings, information and consent are all addressed. A variety of scenarios are covered (examination, blood test, prescription, etc.). Ideally, this book should be used to prepare someone before going to the doctor but it will also be invaluable to General Practitioners and primary health care workers during consultations and before treatments.

£10.00 73pp. 1996 ISBN 1 874439 13 3

When Dad Died

£10.00 60pp. 1989 ISBN 1 874439 06 0

When Mum Died

£10.00 60pp. 1989 ISBN 1 874439 07 9
By Sheila Hollins and Lester Sireling
Illustrated by Beth Webb

These two books take an honest and straightforward approach to death in the family. The pictures tell the story of the death of a parent in a simple but moving way. The approach is non-denominational. One book illustrates a cremation (*When Dad Died*), the other a burial. The books will help to inform readers about the simple facts of death and about feelings of grief. Children without learning disabilities will also appreciate these books which adopt a more direct approach to death than is usual.

A New Home in the Community

£10.00 72pp. 1993 ISBN 1 874439 02 8

Peter's New Home

£10.00 72pp. 1993 ISBN 1 874439 01 X
By Sheila Hollins and Deborah Hutchinson
Illustrated by Beth Webb

These two books are designed to help people with learning disabilities make a happy transition to a new home. *Peter's New Home* tells the story of leaving one's family for a group home while *A New Home in the Community* tells the story of leaving a long-stay hostel or hospital to go to a group home.

Feeling Blue

By Sheila Hollins
and Valerie Sinason
Illustrated by Beth Webb

This book is for people with learning disabilities who get depressed. It shows what happens to the character when he is depressed, and how he is helped to feel better.

£10.00 66pp. 1995 ISBN 1 874439 09 5

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ADVA
DIARY DA

Thinking about management issues in schizophrenia?

As part of a comprehensive programme of initiatives open to psychiatrists, CPNs and pharmacists, we are organising a series of one day multi-disciplinary workshops under the general heading **"Changing Horizons of Care"**.

Presentations and discussion groups will focus on the following:

- Advances in risk assessment and management
- Advances in schizophrenia therapies

28 May	Belfast	11 June	Manchester
28 May	Newcastle	12 June	Glasgow
30 May	Nottingham	16 June	N Thames
30 May	Edinburgh	18 June	Cardiff
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4 June	S Thames	23 June	Exeter
6 June	Southampton	25 June	Oxford

For more information on these multi-disciplinary workshops please call Sally Heap at Zeneca on 01625 712412 or Matt de Gruchy on 0171 229 9922.

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THINKING AHEAD IN PSYCHIATRY

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Goodnight depression

THE FIRST ANTIDEPRESSANT LICENSED FOR PANIC DISORDER†

Good morning world

Because most patients with depression suffer from insomnia and disturbed sleep,[1] an antidepressant should tackle this problem early on.

'Seroxat' has a difference, now well documented in major trials. It has the ability to match tricyclic efficacy in improving sleep by night, without the likelihood of sedation by day.[2,3]

With 'Seroxat', you can give your patients much needed sleep as early as week one.[4] You can lift both depression[5] and anxiety[2] and reduce rather than increase agitation.[6]

It's a real difference for people needing the strength to face reality again, and a real reason to prescribe this SSRI, which is now also indicated for Panic Disorder and Obsessive Compulsive Disorder.

SEROXAT
PAROXETINE

An SSRI that restores restful sleep[7]

20 mg tablets, £20.77; 30 (OP) 30 mg tablets, £31.16. **Indications:** Treatment of symptoms of depressive illness of all types including depression accompanied by anxiety. Treatment of symptoms of obsessive compulsive disorder (OCD). Treatment of symptoms and prevention of relapse of panic disorder with or without agoraphobia. **Dosage:** *Adults: Depression:* 20 mg a day. Review response within two to three weeks and if necessary increase dose in 10 mg increments to a maximum of 50 mg according to response. *Obsessive compulsive disorder:* 40 mg a day. Patients should be given 20 mg a day initially and the dose increased weekly in 10 mg increments. Some patients may benefit from a maximum dose of 60 mg a day. *Panic disorder:* 40 mg a day. Patients should be given 10 mg a day initially and the dose increased weekly in 10 mg increments. Some patients may benefit from a maximum dose of 50 mg a day. Give orally once a day in the morning with food. The tablets should not be chewed. Continue treatment for a sufficient period, which may be several months for depression or longer for OCD and panic disorder. As with many psychoactive medications abrupt discontinuation should be avoided - see **Adverse reactions.** *Elderly:* Dosing should commence at the adult starting dose and may be increased in weekly 10 mg increments up to a maximum of 40 mg a day according to response. *Children:* Not recommended. *Severe renal impairment (creatinine clearance <30 ml/min) or severe hepatic impairment:* 20 mg a day. Restrict incremental dosage if required to lower end of range. **Contra-indication:** Hypersensitivity to paroxetine. **Precautions:** History of mania. Cardiac conditions: caution. Caution in patients with epilepsy; stop treatment if seizures develop. Driving and operating machinery. **Drug interactions:** Do not use with or within two weeks after MAO inhibitors; leave a two-week gap before starting MAO inhibitor treatment. Possibility of interaction with tryptophan. Great caution with warfarin and other oral anticoagulants. Use lower doses if given with drug metabolising enzyme inhibitors; adjust dosage if necessary with drug metabolising enzyme inducers. Alcohol is not advised. Use lithium with caution and monitor lithium levels. Increased adverse effects with phenytoin; similar possibility with other anticonvulsants. **Pregnancy and lactation:** Use only if potential benefit outweighs possible risk. **Adverse reactions:** In controlled trials most commonly nausea, somnolence, sweating, tremor, asthenia, dry mouth, insomnia, sexual dysfunction (including impotence and ejaculation disorders), dizziness, constipation and decreased appetite. Also spontaneous reports of dizziness, vomiting, diarrhoea, restlessness, hallucinations, hypomania, rash including urticaria with pruritus or angioedema, and symptoms suggestive of postural hypotension. Extrapyramidal reactions reported infrequently; usually reversible abnormalities of liver function tests and hyponatraemia described rarely. Symptoms including dizziness, sensory disturbance, anxiety, sleep disturbances, agitation, tremor, nausea, sweating and confusion have been reported following abrupt discontinuation of 'Seroxat'. It is recommended that when antidepressant treatment is no longer required, gradual discontinuation by dose tapering or alternate day dosing be considered. **Overdosage:** Margin of safety from available data is wide. Symptoms include nausea, vomiting, tremor, dilated pupils, dry mouth, irritability, sweating and somnolence. No specific antidote. General treatment as for overdosage with any antidepressant. Early use of activated charcoal suggested. **Legal category:** POM. 1.7.96. † In the UK. **References** **1.** Fleming J. Prog Neuro-Psychopharmacol, Biol Psychiatr 1989;13:419-29. **2.** Hutchinson D *et al.* Br J Clin Res 1991;2:43-57. **3.** Hindmarch I. Int Clin Psychopharmacol 1992;6(Suppl 4):65-7. **4.** Dunbar GC *et al.* Acta Psychiatr Scand 1993;87:302-5. **5.** Medicines Resource Centre. Int Pharm J 1992;6:6-9. **6.** Dunbar GC, Fuell DL. Int Clin Psychopharmacol 1992;6 (Suppl 4):81-9. **7.** Dorman T. Int Clin Psychopharmacol 1992;6(Suppl 4):53.

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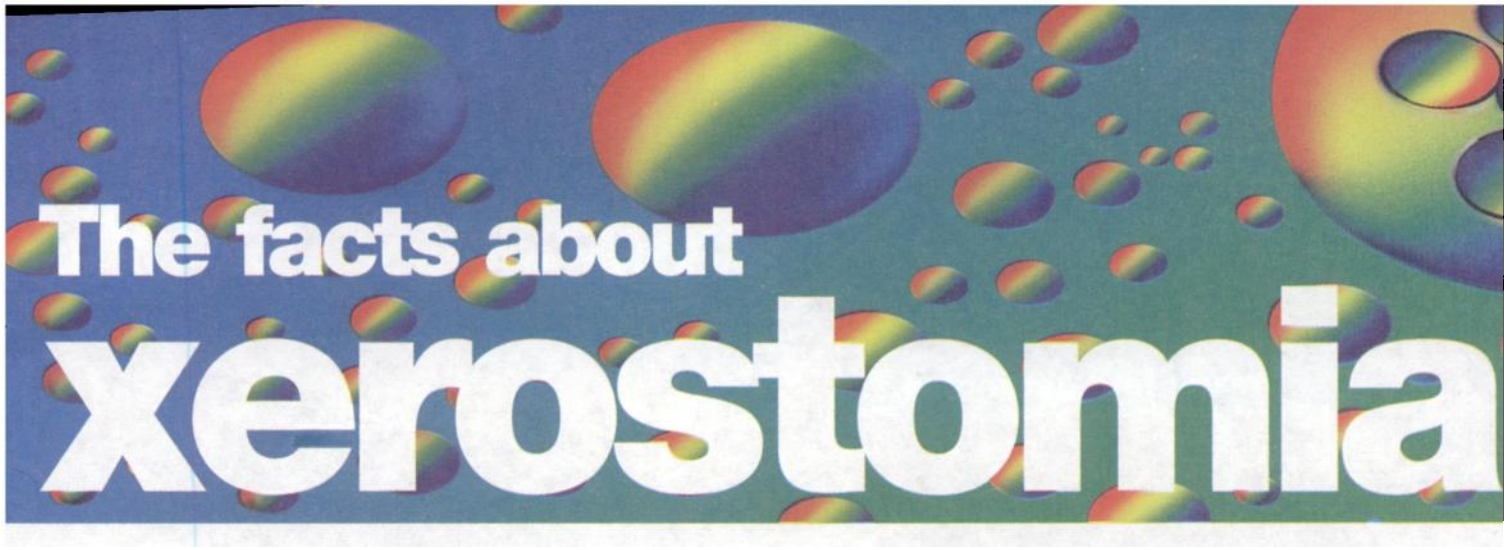

and how extra saliva can help.

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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Professional Speciality: _____

Please return this coupon to The Wrigley Company Limited, PO Box 15, RUGBY, CV22 7BR.

BJP

1. Data on file, The Wrigley Company Ltd. 2. FDI Working Group 10. International Dental Journal 1992; 42(4) Suppl. 2:296. 3. Whelton H *et al.* Data on file, The Wrigley Company Limited. 4. Manning RH *et al.* Caries Res 1991; 25(3): Abstract #78. 5. Leach SA *et al.* J Dent Res 1988;67: Abstract #647. 6. Council on Dental Therapeutics. JADA 1988; 116: 757. 7. Odulosa F. NYSDJ April 1991: 28-31. 8. Markovic N *et al.* Gerontology 1988; 7(2): 71-75 9. Abelson DC *et al.* J Clin Dent 1990; 2(1): 3-5. 10. Edgar WM *et al.* J Dent Res 1981: 60 Spiss. 1137.

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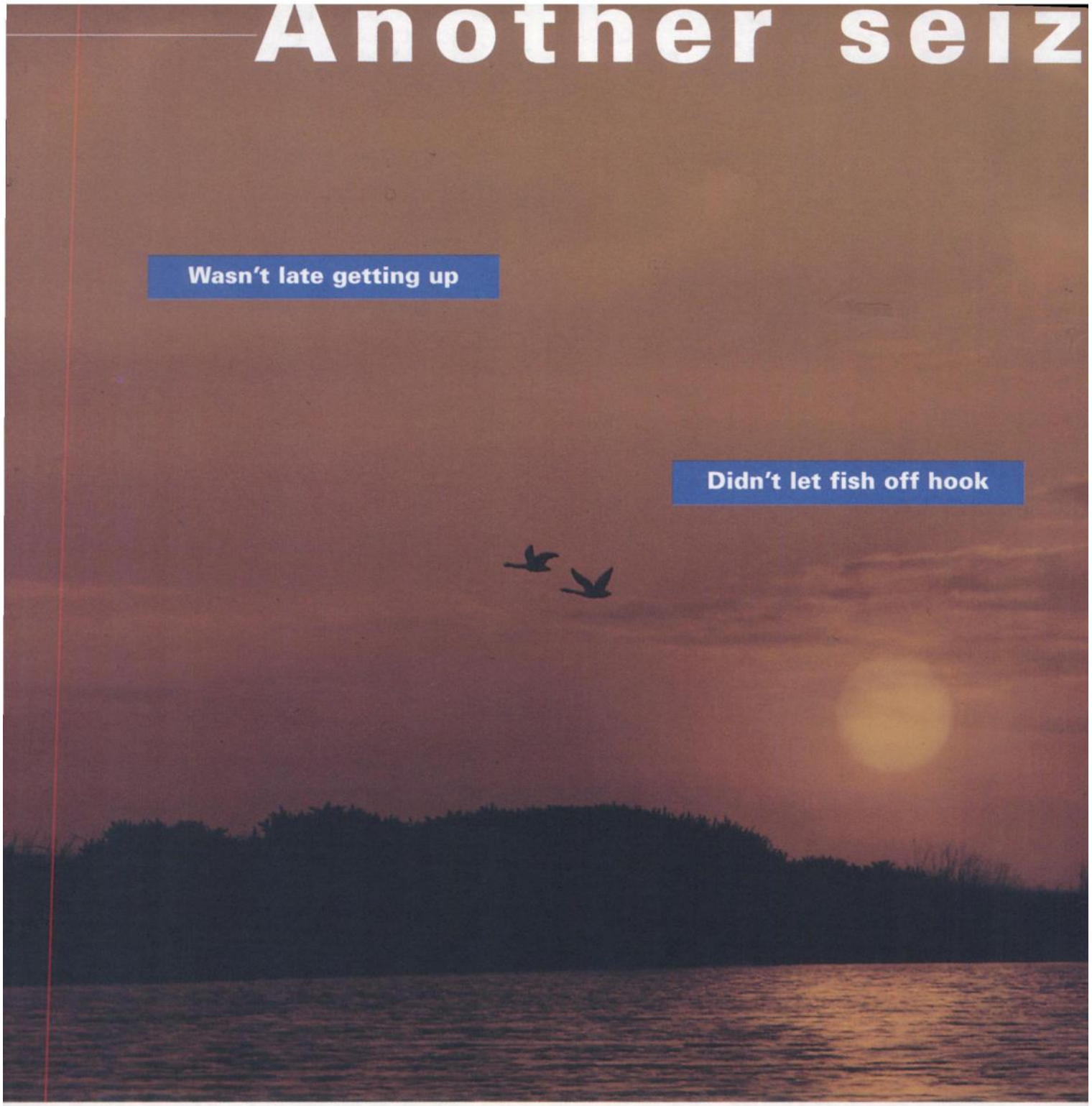
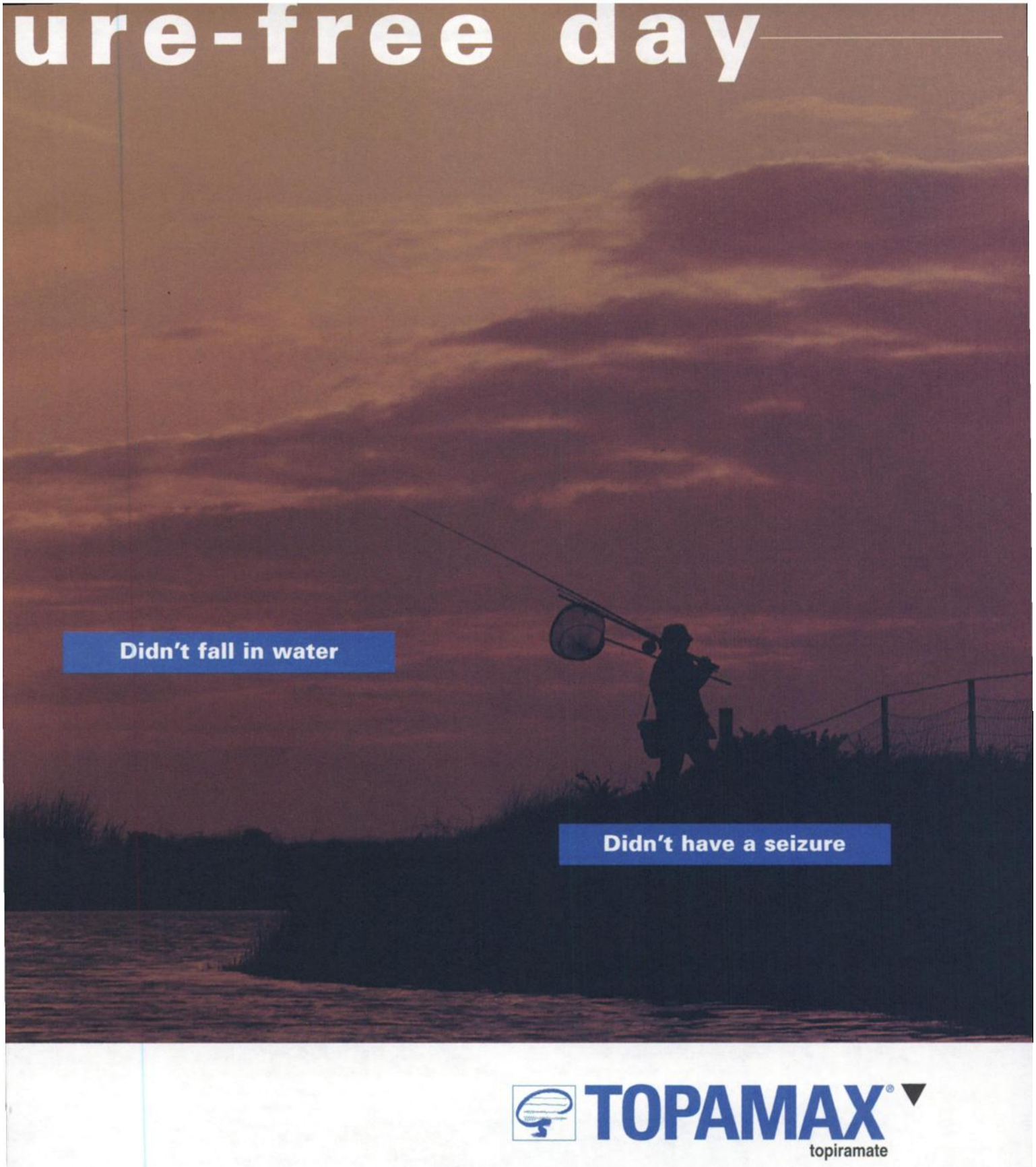


Adjunctive treatment for partial seizures

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. Maximum recommended dose: 800mg/day. Initiate therapy at 50mg bd then titrate to an effective dose. See data sheet for titration. Do not break tablets. It is not necessary to monitor topiramate plasma concentrations. Patients with

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



TOPAMAX®
topiramate

At the end of the day, it works.

with or without secondary generalisation

concentration. No clinically significant changes in plasma concentrations on sodium valproate addition or withdrawal. *Digoxin:* A decrease in serum digoxin occurs. Monitor serum digoxin on addition or withdrawal of TOPAMAX. *Oral Contraceptives:* Should contain not less than 50µg of oestrogen. Ask patients to report any change in bleeding patterns. *Others:* Avoid agents predisposing to nephrolithiasis. **Side Effects:** In 5% or more: ataxia, impaired concentration, confusion, dizziness, fatigue, paraesthesia, somnolence and abnormal thinking. May cause agitation and emotional lability (which may manifest as abnormal behaviour) and depression. Less commonly: amnesia, anorexia, aphasia, diplopia, nausea, nystagmus, speech disorder, taste perversion, abnormal vision and weight decrease. Increased risk of treatment as appropriate. Haemodialysis is effective in removing topiramate. **Pharmaceutical Precautions:** Store in a dry place at or below 25°C. **Legal Category:** POM. **Package Quantities and Prices:** Bottles of 60 tablets. 25mg (PL0242/0301) = £22.02; 50mg (PL0242/0302) = £36.17; 100mg (PL0242/0303) = £64.80; 200mg (PL0242/0304) = £125.83. **Product Licence Holder:** JANSSEN-CILAG LIMITED, SAUNDERTON, HIGH WYCOMBE, BUCKINGHAMSHIRE HP14 4HJ Further information is available on request from the Marketing Authorisation Holder: Janssen-Cilag Limited, Saunderton, High Wycombe, Buckinghamshire HP14 4HJ. ® Registered Trademark Date of Preparation Aug 1996

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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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

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ABBREVIATED PRESCRIBING INFORMATION: Presentation: Coated tablets containing 5mg, 7.5mg or 10mg of olanzapine. The tablets also contain lactose. **Uses:** Schizophrenia, both as initial therapy and for maintenance of response. **Further Information:** In studies of patients with schizophrenia and associated depressive symptoms, mood score improved significantly more with olanzapine than with haloperidol. Olanzapine was associated with significantly greater improvements in both negative and positive schizophrenic symptoms than placebo or comparator in most studies. **Dosage and Administration:** 10mg/day orally, as a single dose without regard to meals. Dosage may subsequently be adjusted within the range of 5-20mg daily. An increase to a dose greater than the routine therapeutic dose of 10mg/day is recommended only after clinical assessment. *Children:* Not recommended under 18 years of age. *The elderly:* A lower starting dose (5mg/day) is not routinely indicated but should be considered when clinical factors warrant. *Hepatic and/or renal impairment:* A lower starting dose (5mg) may be considered. When more than one factor is present which might result in slower metabolism (female gender, elderly age, non-smoking status), consideration should be given to decreasing the starting dose. Dose escalation should be conservative in such patients. **Contra-indications:** Known hypersensitivity to any ingredient of the product. [illegible] narrow-angle glaucoma. **Warnings and Special Precautions:** Caution in patients with prostatic hypertrophy, or paralytic ileus and related conditions. Caution in patients with elevated ALT and/or AST, signs and symptoms of hepatic impairment pre-existing conditions associated with limited hepatic functional reserve, and in patients who are being treated with potentially hepatotoxic drugs. As with other neuroleptic drugs, caution in patients with low leucocyte and/or neutrophil counts for any reason, a history of drug-induced bone marrow depression/toxicity, bone marrow depression caused by concomitant illness, radiation therapy or chemotherapy and in patients with hypereosinophilic conditions or with myeloproliferative disease. Thirty-two patients with clozapine-related neutropenia or agranulocytosis histories received olanzapine without decreases in baseline neutrophil counts. Although, in clinical trials, there were no reported cases of NMS in patients receiving olanzapine, if such an event occurs, or if there is unexplained high fever, all antipsychotic drugs, including olanzapine, must be discontinued.

Lilly PSYCHIATRY

Improving lives, restoring hope

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 teratogenic effects in animals. Because human experience is limited, olanzapine 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 titrated doses of haloperidol. 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.

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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.

Surely this is the ultimate goal.

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