SSRIs have been described to produce EPS and TD (Arya, 1994; Coulter & Pillans, 1995). If brain damage proves to be a common factor it might be as well to bear this in mind when prescribing SSRIs.

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## Psychosurgery for obsessional disorder

SIR: The reviews by Piccinelli *et al* (1995) and James & Blackburn (1995) summarise the current state of knowledge of the outcome of treatment of obsessional disorder by pharmacological and cognitive therapeutic methods. The third major therapeutic approach, not mentioned in the studies, is psychosurgery.

We should like to draw attention to the review of psychosurgery in obsessional disorder (Mindus & Jenike, 1992). A further important outcome study, conducted from one centre, is provided by Hay *et al* (1992).

Both papers indicate that psychosurgery, when conducted by present-day stereotactic techniques, retains an important role in the management of severe obsessional disorder resistant to other treatment. It is important to note that the cingulate gyrus lesion does not appear to have advantage over the techniques based on lesion in the fronto-thalamic radiation.

In Britain the procedure based on radioactive induced lesion, known as subcaudate tractotomy is predominant because of the use of this technique at the major national centre. We have adhered to a simpler and more limited approach by a circumscribed stereotactically placed lesion, 9 mm in diameter, in the fronto-thalamic radiation. An outcome study of our series does not prompt us to abandon the technique (Hay *et al*, 1993).

Sometimes there seems to be an impression that the Mental Health Commission has virtually banned psychosurgery. This is not the case, although rigorous standards are laid down. In the middle decades of this century vociferous denigration of somatic treatment for psychiatric disorder led to the widespread abandonment of psychosurgery. Today the ethics should be questioned of withholding information concerning the existence of treatment which has been shown to offer some chance of relief from suffering. Our survey of psychiatric opinion (Snaith *et al*, 1984) which was undertaken prior to the establishment of the Yorkshire Regional Psychosurgery Service, confirmed that there was a requirement for the service not only for obsessional disorder but also for intractable depressive disorders, and a preference for the regional establishment of such a service.

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JAMES, I. A. & BLACKBURN, I. M. (1995) Cognitive therapy with obsessive-compulsive disorder. *British Journal of Psychiatry*, **166**, 444–450.

MINDUS, P. & JENIKE, M. A. (1992) Neurosurgical treatment of malignant obsessive-compulsive disorder. *Psychiatric Clinics of North America*, **15**, 921–938.

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## Treatment of obsessive–compulsive disorder

SIR: Piccinelli *et al* (1995) seem to sideline exposure therapy given to many OCD sufferers in the UK by writing that although behaviour therapy has been reported to be more effective than pharmacological interventions and to provide long-term improvement with low relapse rate, in reality few patients actually undergo this treatment, *either as a result of refusing to participate, high cost, and/or lack of qualified behavioural therapists* (emphasis added).

The three points in italics deserve correction. First, in controlled studies, OCD patient refusal rates were in fact lower for exposure (behaviour) therapy than for clomipramine. Second, behaviour therapy costs less than medication in the long run as one-off exposure usually produces lasting improvement, whereas medication generally needs to be continued for years to avoid relapse. Finally, there

are now hundreds of clinicians (nurse therapists, psychiatrists, psychologists) doing exposure therapy for OCD throughout the UK. UK purchasers of health care thus have a widely available option of choosing exposure therapy for OCD which is usually acceptable, inexpensive and more effective than is medication. The 30% or so of OCD sufferers who have concomitant depressed mood need both exposure and antidepressants.

Similar sidelining in the *BJP* occurs when Tallis (1995) writes "Behaviour therapy remains the most effective and thoroughly evaluated psychological treatment of OCD" in a section actually devoted to "Cognition and cognitive therapy" and omits discussion of inexpensive yet effective self-exposure therapy. Readers and patients interested in such valuable self-exposure therapy may find it helpful to read Lee Baer's excellent book *Getting Control* (1991).

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PICCINELLI, M., PINI, S., BELLANTUONO, C., *et al* (1995) Efficacy of drug treatment in obsessive-compulsive disorder. A meta-analytic review. *British Journal of Psychiatry*, **166**, 424–443.
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## Clozapine-induced hypersalivation and the alpha2 adrenoceptor

SIR: Hypersalivation can be a troublesome side-effect of clozapine, limiting its usefulness in the management of some cases of schizophrenia (Fitton & Heel, 1990), but the pharmacological basis of this remains obscure. As well as its action at several dopamine and serotonin receptor subtypes, clozapine can block muscarinic acetylcholine receptors and the alpha2 adrenoceptor (Reynolds & Czudek, 1995), which have opposing effects on the control of salivation. While muscarinic blockade leads to diminished salivary secretion, alpha2 antagonists can increase salivation (Berlan *et al*, 1992), suggesting that this latter action may underly clozapine-induced hypersalivation. To test this hypothesis, we administered the alpha2 agonist lofexidine to one patient in whom the side-effect was particularly distressing.

The 54-year-old man had suffered from chronic schizophrenia since 1959. In 1993 he was commenced on clozapine; the dose of clozapine was increased to 900 mg per day and there were improvements in his social interactions, communication and personal hygiene. Unfortunately he had severe hypersalivation which did not respond to thioridazine, procyclidine, or reduction in dose of clozapine to 600 mg daily. With the addition of lofexidine 0.2 mg b.d., there was a significant improvement in the hypersalivation, with nursing staff observing that the previously persistent dripping of saliva onto the patient's clothes quickly ceased. Because of the risks involved lofexidine was not continued for more than one month and it was subsequently necessary to discontinue the clozapine.

Lofexidine is an alpha2 agonist which is licensed in the UK only for the short-term treatment of opiate withdrawal symptoms. It could not be used for long-term treatment without running the risks of depression and exacerbation of psychosis, which limited the usefulness of the similar agent clonidine in mania (Hardy *et al*, 1986), obsessive–compulsive disorder and Tourette's syndrome (Ashanuddin, 1982). However, awareness of the pharmacological basis of the hypersalivation may permit development of strategies to combat this limiting side-effect of a major antipsychotic.

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BERLAN, M., MONTASTRUC, J.-M. & LAFONTAN, M. (1992) Pharmacological prospects for alpha2-adrenoceptor antagonist therapy. *Trends in Pharmacological Science*, **13**, 277–282.
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## Suspected congenital sertraline dependence

SIR: We report the suspected occurrence of neonatal withdrawal symptoms from maternal use of sertraline throughout pregnancy, which as far as we are aware has not been previously reported. Withdrawal syndromes for sertraline, fluvoxamine and paroxetine have been reported to occur in adults (Szabadi, 1992; Louie *et al*, 1994; Pyke, 1995).