In summary we have discussed two patients who developed acute hypomanic symptoms after tapering of their antidepressant treatments. Our cases developed symptoms while inpatients. One would wonder how often this would occur on an outpatient basis and would these patients be aware of the mood switch and present for further treatment. These cases highlight the need for vigilance and close monitoring of the patient with BPAD on discontinuation of antidepressants, particularly in the first four days for the possibility of antidepressant withdrawal induced hypomania.

***Marie Naughton**
Registrar in Psychiatry,
St James's Hospital, Dublin 8
**Darren Roddy**,
Registrar in Psychiatry,
St Edmundsbury Hospital,
Lucan, Co Dublin,
**John Cooney**,
Consultant Psychiatrist,
St James's Hospital,
Dublin 8, Ireland.
**Correspondence*

**References**
1. Kupfer D et al. Five-year outcome for maintenance therapies in recurrent depression. Arch Gen Psychiatry 1992; 49: 769-73.
2. Post RM et al. Prophylactic efficacy of carbamazepine in manic-depressive illness. Am J Psychiatry 1983; 140: 1602-04.
3. Suppes T et al. Risk of recurrence following discontinuation of lithium treatment in bipolar disorder. Arch Gen Psychiatry 1991; 48:1082-88.
4. First MB, Spitzer RL, Gibbon M et al. Structured Clinical Interview for DSM-IV Axis 1 Disorders-patient edition (SCID-I/P, Version 2.0). New York, NY: Biometric Research, New York State Psychiatric Institute: 1995.
5. Mirin SM, Schatzberg AF, Creasey DE. Hypomania and mania after withdrawal of tricyclic antidepressant. Am J Psychiatry 1981; 138: 87-89.
6. Steven M, Mirrin MD, Schatzberg MD, David E, Creasey MD. Hypomania and mania after withdrawal of tricyclic antidepressants. Am J Psychiatry 1981; 138: 87-89.
7. Dilsaver SC, Greden JF. Antidepressant withdrawal Phenomena. Biol Psychiatry 1984; 19: 237-56.
8. Chittaranjan A. Antidepressant - withdrawal mania: a critical review and synthesis of the literature. J Clin Psychiatry 2004; 65: 987-93.

# Discontinuation syndrome *en masse*

*Dear Editor* – Every psychiatrist will have at least one. The patient who had a psychosis that blazed for years, apparently untreatable, until thioridazine quelled the flames. Then things stabilised for some years. Until thioridazine (or the tranylcypromine/trifluoperazine combination Parstelin, or whichever now discontinued drug) was withdrawn, or withdrawal was threatened. "They've never been right since," the CPN or hostel CNM will say. Often the only answer seems to recommence the discontinued drug, if possible. This then continues until production is ceased. Thioridazine has been dancing on the volcano of complete discontinuation for what seems like forever. Carers, professionals and patients themselves look forward with apprehension to the day of its complete disappearance.

Drugs are discontinued for a range of reasons. Some are withdrawn because of safety concerns, such as both of the examples above. Others have their production ceased for economic reasons. Some preparations are only made by the smaller companies of the pharmaceutical industry. These of course are more vulnerable to the vicissitudes of commerce.

The association of some older medications with sudden death and prolonged QTc interval is well known.[1] Newer medications, of course, increasingly are known to have associations with deleterious physical outcomes. Olanzapine, for instance, is diabetogenic and associated with obesity and resultant increase in lipid profile.

It is important that the safety of medications is rigorously policed by regulatory bodies. Psychiatric patients deserve, as much as any other patient group, to have their physical health secure from the medications supposed to help them.

In the case of psychotropic medication, however, there is an issue of a stability from a psychiatric point of view. It can often be difficult to find the medication or the right combination of medication to stabilise a particular individual. In researching this issue, there is an absolute paucity of work on the psychological effects on patients and their carers of drug discontinuation, as well as the direct effect on mental state on the withdrawal of a previously effective medication. The psychological effect of discontinuation does not seem to be taken into account by regulatory bodies. The makers of thioridazine are unaware of any research on the psychological impact of the discontinuation of the drug.[2]

There is an assumption that withdrawal of one agent can simply be compensated for by replacement with another, newer one. Clinical experience – such as the patient "who was only ever right on Melleril" discussed above – tells us otherwise. Each patient is an individual, whose response to any particular agent or combination of agents in the pharmacopoeia is individual and – until, perhaps, the genetic basis of neurotransmitter regulation is a more exact science – unpredictable.

On a population basis new atypical antipsychotic A may be more efficacious and less 'dirty' (although give it time) than venerable typical antipsychotic B, but the primary duty of any doctor is to the individual patient across the desk or in the bay bed.

Patient advocacy groups both here and in the UK are greatly concerned with the minimisation of side effects and, when necessary, the withdrawal of potentially hazardous medications.[3] This is of course laudable and extremely necessary. However one wonders how much suffering has been caused by the abrupt and enforced discontinuation of these drugs.

With many drugs with an adverse side effect profile, availability on a named patient basis continues. Thalidomide, which is in the public mind the most poignant and resonant example of a drug with disastrous side effects, has made something of a comeback, with a recognition that it is an effective treatment for multiple myeloma, discoid lupus erythematosus, leprosy and certain dermatological conditions.[4]

Could not psychotropic medications that have a similar track record of effectiveness be made available, on a named patient basis and under stringent safeguards, rather than being abruptly discontinued? Patients too could and should be involved in the decision. There is something of a misapprehension that psychiatric patients are simply unable to



https://doi.org/10.1017/S079096670001017X Published online by Cambridge University Press

handle this kind of information. With some exceptions, this is generally not the case. Patients have more comfort with awareness of risk, and with investigations and monitoring of potential effects on general health, than they are sometimes given credit for. Awareness of side effects, including potentially fatal ones, does not necessarily destroy compliance. We should assume, unless there are very good reasons to indicate otherwise, that our patients are capable of informed consent.

Should we consider that drug companies have an ethical duty to provide the option of continuing discontinued treatments? The technical knowledge need to produce a certain pharmaceutical is not actually lost.

Economic reasons presumably are a major factor. If it is the case that producing certain drugs would be a crippling undertaking for a private enterprise, do drug regulatory bodies, governments or even the World Health Organisation have a responsibility to ensure the continued production, or even continue production, of drugs forcibly discontinued?

Furthermore, individual preparations of certain medications and even individual doses are often suddenly discontinued. For instance, venlafaxine in 75mg doses was not available for a spell. Doctors tend to uncomplainingly accept the pharmacist informing them that "they've stopped making that strength" as just one of those things.

Psychiatric patients have repeatedly, *en masse*, been subjected to a sort of experiment in drug discontinuation. Clinical stability for psychiatric patients is not a trivial consideration, easily sacrificed. It is central to our patients experience of the world. The pharmaceutical industry, regulatory bodies and the medical profession itself have a duty to ensure the availability, under tight control if need be, of the preparations that help to ensure this clinical stability.

**Seamus McSuibhne**, Registrar,
St Patrick's Hospital,
***Declan Lyons**,
Consultant Psychiatrist
St Patrick's Hospital,
James's St,
Dublin 8,
Ireland

**Correspondence*

References
1. Calderone V, Cavero I. Ventricular arrhythmias. A potential risk associated with the use of non-cardiovascular drugs prolonging the QT interval. Minerva Med 2002; 93(3): 181-97.
2. Based on personal communication with Novartis Ireland Medical Director and Medical Affairs Manager
3. Based on personal communication with SANE and MIND
4. Brocard A, Barbarot S, Milpied B, Stalder JF. Thalidomide in the treatment of chronic discoid lupus erythematosus. Ann Dermatol Venereol 2005 ;132(11 Pt 1): 853-6.





https://doi.org/10.1017/S079096670001017X Published online by Cambridge University Press