

ming suicidal impulses. With a knife, he cut off his left hand almost entirely, feeling no pain when cutting. After extensive surgical intervention, the hand was saved. He gradually returned to his habitual state.

In the second case, Mr B, 53 years old, had been treated with venlafaxine for 7 months because of a mixed anxious-depressive state. Most of the time, the dose was 150 mg daily. The effect was initially good, but declined when side effects such as impotence became disturbing. It was then decided to stop venlafaxine, and the dose was tapered from 150 mg daily to 0 during 2 weeks. During the tapering period, he had nausea and paresthesias. A week after the last dose of venlafaxine, he began experiencing dizziness which became rapidly worse. He had never suffered from this before. He could not perform his usual activities, and reported falling and hurting himself several times. His general practitioner could not find any physical cause. Cardiovascular function and laboratory tests were normal. His other medication, zolpidem 10 mg for insomnia, was unchanged all the time. After about 5 weeks of a somewhat fluctuating course, the dizziness gradually decreased, and after 7 weeks he felt normal.

Mr A's behaviour could perhaps be attributed to extremely increased anxiety caused by 10 mg citalopram, but we do not know of any such case reports. The symptoms of Mr B during the tapering period were similar to some of those described by Louie et al (1996). These authors also describe withdrawal symptoms of psychotic quality. The extreme anxiety of Mr A seemed to approach psychotic intensity.

Both patients experienced unusual and disturbing symptoms starting about 1 week after their last dose of venlafaxine. Obviously, we can not claim for certain that these late symptoms were indeed part of a withdrawal reaction. However, in both cases the time coincidence seems noteworthy. Our cases may alert clinicians to be aware of possible similar emergence of new symptoms after discontinuation of venlafaxine.

After the first version of this letter was submitted, we have noted some more cases of possible venlafaxine withdrawal reactions. Such cases may add emphasis to recommendations of careful tapering of venlafaxine (Faraii and Lauer, 1996; Louie et al, 1996).

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Client satisfaction in a clozapine clinic

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The use of clozapine is complicated because of the need for mandatory hematological monitoring which may affect patient compliance (Meltzer, 1992; Paton and

Wolfson, 1995). Patients prescribed clozapine need to be informed about possible side effects, as well as the need for hematological monitoring. A clozapine clinic was set up in our hospital in order to fulfill these requirements and also to monitor clinical progress. The aims of this study were first to measure client satisfaction with the new service, and second to examine the relationship between client satisfaction and clinical outcome. A clozapine clinic was developed in our hospital in order to centralize the administration and hematological monitoring of clozapine, and to follow clinical progress, and detection of side effects. The clinic is staffed by a senior registrar and two members of nursing staff. Patients attend on an appointment basis. The mental state of each patient is assessed at each visit as well as their full blood count, blood pressure and weight. After each visit, clinic staff liaise with each patient's consultant regarding their clinical progress, which provides continuity of care for the patients. Patients return later in the week or 2 weeks later to collect their medication. Patients attending the clinic fulfilled DSM-III-R criteria for schizophrenia, which was confirmed as treatment refractory. Psychopathology was assessed initially, and after 6 months by means of the Brief Psychiatric Rating Scale (BPRS). Client satisfaction was also measured at 6 months, using the Client Satisfaction Questionnaire (CSQ-8) (Larsen et al, 1979). The CSQ-8 is a measure of general satisfaction with services and was developed to provide a brief, standard assessment procedure suitable for use in a wide variety of service settings. The CSQ was administered to patients by a psychiatrist (LH), who was not involved with the clozapine clinic. Data was analyzed using SPSS. There was a total of 28 patients (19 males and nine females) attending the clinic during the study period. All patients agreed to participate in the study. The age range of patients was 19–65 years with a mean of 32.8 (SD: 14). The mean initial BPRS score was 65 (SD: 14) and this decreased to a mean of 46 (SD: 12) following 6 months of clozapine therapy ($P \leq 0.0001$). The mean dose of clozapine used was 400 mg (SD: 150 mg). The mean client satisfaction score was 27.4 (SD: 3.5), indicating high levels of satisfaction. The decrease in mean BPRS scores at 6 months correlated inversely with the client satisfaction scores ($r = -0.32$, $P \leq 0.05$). The importance of recognizing the consumers' view when planning psychiatric services has been previously noted (Murphy, 1988). This study demonstrates that patient satisfaction levels in a specialized clozapine clinic are high. A significant reduction in BPRS scores followed treatment with clozapine. Client satisfaction as measured by the client satisfaction questionnaire, and symptom reduction measured by the BPRS are positively associated.

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Meltzer HY. Dimensions of outcome with clozapine. *Br J Psychiatry* 1992;160(Suppl 17):46–53

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