provide guided mourning to these patients to aid the process of grieving with the aim of treating their depression with or without the use of antidepressants. Orrell & Bebbington conclude that demented patients respond to the stress of life events just as cognitively intact individuals do; our strategy for management acts on the belief that they respond to the same intervention as cognitively intact individuals. Sometimes relatives, in believing they are acting in the best interest, do not tell their demented relative about a death in the family thereby denying them the chance to grieve.

Further work is needed on the effect of bereavement on dementia sufferers; this has theoretical, ethical and clinical implications.

ORRELL, M. & BEBBINGTON, P. (1995) Life events and senile dementia. Affective symptoms. *British Journal of Psychiatry*, **166**, 613–620.

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Community care in presenile Alzheimer's disease

SIR: Newens *et al.* (1995) discuss the use of community and support services by carers, and comment that sufferers are managed for a considerable period at home if they have a living relative, despite a severe degree of dementia and loss of independence. While in no way minimising the love and care shown by relatives, it must be allowed that one of the reasons for continuing to care at home is financial. Consider the following case study.

BB, a self-employed professional man, retired early due to memory problems. His two children are young teenagers, with many years of schooling ahead, his wife does not work. He receives attendance allowance and a private pension, together with income from earlier investments. He is now severely demented, incontinent, has disturbed sleep, and is often physically aggressive towards his sons, possibly because he does not recognise them. They no longer invite friends to the house, their school work is suffering. His wife is supported by six days of day care (in two facilities) and extended respite (in a third) to cover as much of the school holidays as possible.

If this unfortunate man were placed in a specialist nursing home his quality of life would probably improve as he would have consistent care on one site with visits from his caring family no longer under such stress. However his wife would have to register for income support and his children leave their private school as his income and savings would be taken for his care. Her lawyer has advised she file for divorce as this would enable her to claim half his savings, and the house, together with "alimony" to support herself and the children! She does not wish to do this. Application for him to be considered a "special case" for NHS funding has been unsuccessful.

The wider politics of paying for one's care in old age are frequently discussed, but until this problem for families of those with presenile dementia is more widely recognised, they will also "pay".

NEWENS, A. J., FORSTER, D. P. & KAY, D. W. K. (1995) Dependency and community care in presenile Alzheimer's disease. *British Journal of Psychiatry*, **166**, 777–782.

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Repeat prescription antidepressants and residential care

SIR: *Defeat Depression* provided valuable information on the detection of depression and the role of antidepressant medication (Department of Health, 1993). However the guidelines on continuing management are not so clear.

Even with primary care becoming more proactive it is still being reported that patients in residential care are being treated for long periods without careful follow-up (Gosney *et al*, 1991). This group tend not to attend surgeries and it is usually a professional carer that requests their repeat prescription. Being a predominantly elderly group they are at increased risk of morbidity due to drug side-effects and interactions.

A survey of patients of a West Midlands GP surgery was undertaken providing data on those in residential homes on monthly repeat prescriptions of tricyclic antidepressants. Excluding those under regular review from psychiatric services gave a study group of 17. Two were men and 15 were women, with an age range of 68–91.

Duration of treatment to the date of the study varied from 8–918 weeks of continuous treatment (mean 190 weeks). The upper end of the range is alarming as is the lowest as one patient had been

put on repeat prescription after only one month of treatment. Less than half had a written diagnosis of depression and over half had no clear start date recorded for treatment. Most had been seen for some reason within the previous three months and all within 9 months but there was patchy recording of information concerning the mental state. Only three of the 17 patients had a documented statement in the notes or in a hospital letter concerning the need for prolonged treatment.

Of the study group seven patients had some form of cardiac disease, two were admitted to hospital with severe constipation and one developed symptoms of prostatic obstruction. There was no mention in the notes of a need to review the antidepressant medication. The indications for the continuation and prophylactic stages of drug treatment are laid out in Paykel & Priest's (1992) consensus statements on the recognition and management of depression in general practice. Further guidelines on continuation or cessation of treatment and recording of clinical information may be useful to those in primary care. This may also apply to professional carers who sometimes bridge the gap between patient and doctor.

DEPARTMENT OF HEALTH (1993) *Defeat Depression. Recognition and Management of Depression in General Practice.*

GOSNEY, M., TALLIS, R. & EDMUND, E. (1991) Biochemical abnormalities in elderly persons in part II homes. *Care of the Elderly*, **3**, 485–488.

PAYKEL, E. S. & PRIEST, R. G. (1992) Recognition and management of depression in general practice: consensus statement. *British Medical Journal*, **305**, 1198–1202.

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Clozapine-induced hypotension treated with moclobemide and Bovril

SIR: The use of clozapine is complicated by a wide range of adverse effects (Alphes *et al*, 1991). Hypotension occurs in 25% of patients treated with clozapine (Gaerner *et al*, 1989) and postural hypotension in 17% (Naber *et al*, 1992). In our experience, clozapine-induced hypotension is a major cause of patient morbidity which often contributes to patients' decisions to withdraw from therapy.

Moclobemide is a reversible inhibitor of monoamine oxidase-A licensed for the treatment of depressive illness. In combination with tyramine contained in Bovril, it induced a modest but useful rise in blood pressure in a patient with central autonomic failure (Karet *et al*, 1993). We report the successful use of moclobemide and Bovril in a patient with clozapine-induced hypotension.

A 26-year-old, 61 kg male was admitted to Bethlem Royal Hospital having failed to respond to conventional neuroleptic medication. On admission his standing blood pressure was 120/80 mm Hg.

All other medication was withdrawn and clozapine started at 25 mg at night. On day 3 of therapy, the dose was increased to 50 mg at night, rising to 75 mg at night on day 5. On day 7, the dose was further increased to 100 mg at night but the patient complained of severe dizziness and was seen by the duty doctor. Standing blood pressure was found to be 90/60 mm Hg with a postural drop of greater than 20 mm Hg.

On day 9, the clozapine dose was increased to 125 mg at night. By day 12, the patient still complained of severe dizziness and standing diastolic pressure was unrecordable. Clozapine was reduced to 50 mg twice daily. Some improvement ensued but standing blood pressures (measured twice daily on days 9–22) remained in the range 110–80 mm Hg systolic, 80–40 mm Hg diastolic and the patient continued to complain of dizziness.

By day 22, no improvement in mental state had occurred but the dose of clozapine could not be increased for fear of severe hypotension. Moclobemide was started at a dose of 150 mg three times daily. With each dose, half a measure (6 g) of Bovril was given. From day 22 to day 26, standing blood pressure (measured twice daily) was in the range 110–100 mm Hg systolic, 80–60 mm Hg diastolic. On day 26 the dose of Bovril was increased to one measure (12 g) three times daily. After this time, twice daily standing blood pressure measurements were in the range 130–110 mm Hg systolic, 90–70 mm Hg diastolic. The patient did not complain of any adverse effects after day 26 despite daily questioning by nursing staff.

The introduction of moclobemide/Bovril also allowed substantial increases in the dose of clozapine. By day 54, the dose had risen to 250 mg/day (75 mg am, 175 mg pm) and the patient's mental state had improved significantly.

Hypotension is a troublesome adverse effect of clozapine. The combination of moclobemide and Bovril appears to be a safe and effective method of ameliorating this common problem. The use of the combination may also decrease the number of patients discontinuing clozapine and, at the same time, allow more effective use of the drug.

ALPHES, L. D., MELTZER, H. Y., BASTANI, B., *et al* (1991) Side-effects of clozapine and their management. *Pharmacopsychiatry*, **24**, 46.