the columns

correspondence

The development of leukaemia in a patient receiving clozapine

Sir: Patients receiving clozapine must be registered with the Clozaril Patient Monitoring Service (CPMS) for regular haematological monitoring to reduce the risk of agranulocytosis. We report the case of a 55-year-old patient with a 26-year history of paranoid schizophrenia, whose illness had been well-controlled for 4 years with 400 mg clozapine. Unfortunately, the development of chronic lymphocytic leukaemia necessitated withdrawal of clozapine, resulting in a florid relapse of schizophrenia.

A review of the previous test results revealed they were consistently reported as 'green' by the CPMS, despite a gradually rising total white cell count from 8 to 20 over the previous 3 years. The total white cell count ranged from 11 to 15 until a recent increase to 20. As this patient's schizophrenia was well controlled on clozapine, this was continued until diagnosis of chronic lymphocytic leukaemia was made at routine review. A subsequent haematological opinion has not suggested any treatment.

There are isolated reports of leukaemia associated with clozapine, but the observed rate is probably the same as the background incidence, with little evidence of a causal relationship. Other haematological abnormalities have been reported in patients taking clozapine, including leucocytosis, lymphopenia, eosinophilia, thrombocytopenia and anaemia (Mendelowitz *et al*, 1995; Barbui *et al*, 1997). Clinicians should be aware that the CPMS only monitors for a low total white cell and neutrophil count. They should therefore remain alert to the possibility of less common haematological disorders and should not rely entirely on a 'green' result from the CPMS.

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Imad M. Ali Consultant Psychiatrist, **Toyin Adeyemo** Senior House Officer, Bro Morgannwg NHS Trust, Coity Clinic, Princess of Wales Hospital, Coity Road, Bridgend CF31 1RQ

Psychiatric liaison service

Sir: We read with interest the description by Nadkarni *et al* (2000) of their experience of running a psychiatric liaison service in a probation hostel. They note that "there is only one bail hostel (in Birmingham) within the criminal justice system specifically for mentally disordered offenders". They also note that they "are not aware of any established services providing psychiatric input to probation hostels".

In fact, there are now three approved bail and probation hostels specifically for mentally disordered offenders – in Birmingham, London and Manchester. The first of these, Elliott House in Birmingham, was established in 1993 through partnership between the West Midlands Probation Service and the Regional Forensic Psychiatric Service at Reaside Clinic. Since that time, multi-disciplinary psychiatric input has been provided to the hostel, including twice weekly out-patient reviews by psychiatrists, a community psychiatric nurse clinic and occupational therapy group and individual work. In addition, there is a weekly inter-agency multi-disciplinary review meeting at which all residents are discussed by mental health and probation staff. The joint aims of the probation and mental health staff providing input into Elliott House are to prevent unnecessary remands of mentally disordered offenders in custody, provide assessment and appropriate treatment where necessary, facilitate connection with local mental health and social services, attempt to reduce the risk of future reoffending and assist courts in making appropriate sentences. Over the years there has been an increasing emphasis on providing a stable environment for a number of mentally disordered offenders made subject to a probation order, often with a condition of residence and treatment.

Most of the residents at Elliott House suffer from a severe mental illness (Geelan *et al*, 1998/99). It is common for individuals to be diverted from custody because of the availability of a specialised facility. Often individuals have been declined accommodation by other probation hostels precisely because of their mental illness. In addition, the presence of a mental illness is associated with a greater likelihood of being remanded in custody (Birmingham, 1999). Therefore it is not safe to assume, as Nadkarni *et al* (2000) suggest, that the high rate of mental disorder in the prison population predicts a high rate in the probation population. In fact, only 12 referrals were received by the service described, of which four were diagnosed with a primary mental illness. Only one was diagnosed as suffering from a severe mental illness. The other three may have been appropriately managed by a general practitioner. The assertion that resource implications were 'minimal' may need to be re-evaluated in light of such a low yield of mental illness.

Nonetheless, it is encouraging to see others advocating increased partnership between mental health services and the probation service. The development of such links requires careful thought and planning in order to target those at high risk of severe mental illness and to overcome the pitfalls to such inter-agency working that have been previously noted by the Probation Service (HM Inspectorate of Probation, 1993).

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J. Kenney-Herbert Consultant in Forensic Psychiatry, **T. Clark** Specialist Registrar in Forensic Psychiatry, **M. Humphreys** Senior Lecturer in Forensic Psychiatry, Reaside Clinic,

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