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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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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Triage in emergency psychiatry

Sir: The concept of triage in emergency psychiatry is an interesting one, clearly elucidated by Morrison *et al* (*Psychiatric Bulletin*, July 2000, **24**, 261–264). Their flow chart elegantly illustrates the process by which cases should be allocated for assessment and one would hope that these considerations would be made in all cases as the number of urgent referrals constantly increases.

However, the final tier of the diagram is perhaps unrepresentative of the resources and manpower available in many departments of psychiatry. There may not be a specialist registrar within the unit and clinical assistants are often part-time, or employed for specific sessions such as day hospital or out-patient clinics. This reduces the staff available to the consultant and senior house officer(s) or the 'on-call' senior house officer. I suspect in practice that the majority of general hospital and accident and emergency referrals are in the first instance dealt with by junior staff, as well as a large proportion of urgent general practitioner referrals. Difficulties may be compounded by manpower shortages and reluctance of locum consultant staff to take on urgent work, other than in a supervisory capacity. In addition, there is rarely a good system in place for monitoring the level of, and response to, emergency referrals.

Although with adequate supervision emergency assessments provide an excellent learning experience for trainees, I feel that their role in the triage and assessment of emergency psychiatric referrals should be clarified and the experience of a senior colleague in providing effective triage utilised to the full.

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Detoxification from heroin with buprenorphine

Sir: There are a number of options available for detoxification from heroin, including methadone tapering regimes, dihydrocodeine reduction, lofexidine, and ultra-rapid naltrexone assisted detoxification under general anaesthetic (Sievewright, 2000). Buprenorphine has recently been licenced in the UK for the treatment of opiate dependence and offers an alternative method of withdrawal from heroin; it has proven efficacy for out-patient detoxification (O'Connor *et al*, 1997) but has been little used in the UK. Here we present the results of a pilot study of 30 consecutive out-patient detoxifications with patients who were using low-dose heroin (£20 approximately 0.2 g daily) using buprenorphine with a standard treatment protocol lasting 7 days.

Of the 30 patients who participated in the study, 15 (50%) successfully completed the detoxification programme and 15 (50%) defaulted. Symptom control appears to have been good, with subject showing mild to moderate withdrawal symptoms throughout the detoxification. The consumption of the medication was easily supervised by clinic staff, ensuring good compliance.

This suggests that, for some opiate dependent patients, a standard prescription protocol of buprenorphine can be used effectively for out-patient heroin detoxification with good compliance and good symptom control. However, as of yet there is no evidence to suggest which type of detoxification is the most effective in terms of matching to patient variables, cost, completion rate or symptom control. Leeds Addiction Unit is currently undertaking a randomised control trial of lofexidine *v.* buprenorphine to look at these issues in detail.

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Learning disability in psychiatry – the future of services

Sir: I support what O'Dwyer (*Psychiatric Bulletin*, July 2000, **24**, 247–250) describes of her experiences as a consultant psychiatrist in learning disability. Her difficulties were recognised by other psychiatrists in the UK. Of fundamental influence on the workload of community teams in learning disability are the number of independent care homes in a catchment area rather than the size of the general population. Poor training and a high turnover of care staff compound the difficulties inherent in the workload that the psychiatrist and the mental health team can expect.

With the move to 'normalisation' of learning disability services since the closure of the institutions and the 'de-medicalisation' of care, I believe services have been hijacked by well-meaning professionals and carers who choose not to recognise, or remain ignorant of, mental illness in this group of people. Ultimately they do a disservice to their clients, which in many cases results in eviction from homes because of difficult behaviour or the inappropriate prescription of potent drugs by general practitioners and general psychiatrists. Unfortunately they too can hold society's prejudice towards the learning disabled and thus further stigmatise their patients.

In planning services, the importance of well-resourced mental health teams in learning disability cannot be ignored because society has a lot to gain from the understanding of mental health issues in learning disability, which has the potential for skills and treatments to be generalised to other groups in the population.

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Serotonin syndrome

Sir: Mir and Taylor's review of serotonin syndrome (*Psychiatric Bulletin*, December 1999, **23**, 742–747) stated that in practice lithium was well tolerated in combination with a selective serotonin reuptake inhibitor (SSRI), but mentioned four individual reports where problems had been experienced. Two of these involved the emergence of serotonin syndrome after the addition of lithium to the treatment regime of a patient already taking an SSRI without side-effects. I would like to add to these a further case seen as an emergency referral to our Affective Disorders Clinic in May 2000.

Mr B is a 53 year old professional white male who has been suffering with recurrent depressive episodes for the last 18 months. He had been treated with various antidepressants during this time. At the time of his urgent referral he had been taking paroxetine 60 mg daily for over 3 months, to which lithium 400 mg daily had been added 2 weeks previously.

On presentation Mr B described profound nausea with the addition of five of Sternbach's diagnostic criteria for serotonin syndrome: agitation, myoclonus, shivering, tremor and incoordination. Serum lithium levels at this time were within normal limits. Lithium was discontinued and the paroxetine was reduced slowly over the next 6 weeks. Within a week Mr B's symptoms had improved and on 3 week review he was symptom-free with regard to the serotonin syndrome.

The above case of serotonin syndrome was attributed to the addition of lithium to the SSRI. This was because he was side-effect-free on treatment with paroxetine and the symptoms developed shortly

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