by her symptoms (continuous preoccupation with dirt and contamination resulting in hours being spent in the bath and inability to leave her home). She spent long periods as a hospital in-patient. In April 1987, the patient was prescribed fluvoxamine 50 mg b.d. There was a good therapeutic response, and the patient was discharged from hospital. In April 1988, after a year's treatment with fluvoxamine, the patient became pregnant, and her general practitioner advised her to stop the fluvoxamine. The patient, however, claimed that she was unable to stop her fluvoxamine; whenever she had tried to do so, she was overwhelmed by strong feelings of aggression (she felt that she "could murder someone"). As Duphar Laboratories, the manufacturers of fluvoxamine, were unaware of any adverse reports on the drug in pregnancy, and the patient's mental state was likely to deteriorate after discontinuation of medication, the patient was allowed to continue on her fluvoxamine throughout her pregnancy. The pregnancy was uneventful, and the patient gave birth to a healthy daughter. Later, when the dosage of fluvoxamine was increased to 150 mg daily, the patient reported a new form of withdrawal syndrome: on the first day after stopping the medication she felt elated and had general features of hypomania (overactivity, racing of thoughts, lack of fatigue). On the second day, however, the aggressive feelings and thoughts appeared. While the patient found the hypomanic phase pleasant, she described the aggressive phase as unbearably distressing.

The bi-phasic withdrawal syndrome probably reflects the activation of two different mechanisms as the concentration of fluvoxamine declines in the brain: the drop in concentration from a higher level would trigger the hypomanic syndrome, whereas the fall in concentration from a lower level would result in the aggressive feelings. Indeed, when the patient was on the lower dosage (100 mg/day) of fluvoxamine, only the aggressive phase was reported.

The most plausible explanation for the withdrawal syndrome is that it reflects a relative deficiency of 5-HT at central 5-HT receptors. In the presence of fluvoxamine the uptake of released 5-HT is continuously blocked, resulting in the exposure of the receptors to a high concentration of 5-HT. This in turn could lead to "down-regulation" (desensitisation) of the receptors. When fluvoxamine is withdrawn, the concentration of 5-HT falls at the receptors to a level that is not sufficient to provide an adequate agonist stimulus for the down-regulated receptors. Indeed, a deficiency in 5-HT has been implicated in the pathogenesis of aggressive and impulsive behaviours (Coccaro, 1989). It is more difficult, however, to link the hypomanic syndrome to a deficiency in 5-HT since mania is thought to be associated with excessive concentrations of 5-HT at central 5-HT-ergic synapses (van Praag, 1978). A similar mechanism has been implicated in the pathogenesis of the neuroleptic malignant syndrome provoked by the discontinuation of levodopa therapy in Parkinsonian patients: stopping the medication leads to an acute relative deficiency of dopamine at central dopaminergic synapses (see Addonizio & Susman, 1991).

I am not aware of other reports of a fluvoxamine withdrawal syndrome, and would be interested to hear from colleagues whether their patients reported similar experiences when withdrawn from fluvoxamine or other selective 5-HT uptake inhibitors (e.g. fluoxetine, paroxetine, sertraline).

ADDONIZIO, G. & SUSMAN, V. L. (1991) *Neuroleptic Malignant Syndrome: A Clinical Approach*. St Louis: Mosby Year Book.

COCCARO, E. F. (1989) Central serotonin and impulsive aggression. *British Journal of Psychiatry*, **155** (suppl. 8), 52–62.

GOODMAN, W. K., PRICE, L. H., DELGADO, P. L., *et al* (1990) Specificity of serotonin reuptake inhibitors in the treatment of obsessive–compulsive disorder. Comparison of fluvoxamine and desipramine. *Archives of General Psychiatry*, **47**, 577–585.

VAN PRAAG, H. M. (1978) Amine hypotheses of affective disorder. In *Handbook of Psychopharmacology*, Vol 13 (eds L. L. Iversen, S. D. Iversen & S. H. Snyder), pp. 187–297. New York: Plenum Press.

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A HUNDRED YEARS AGO

The devices adopted in other places for showing accommodation which does not exist are not good. In the case of Maryborough Asylum, above referred to, we learn that "there is no Board-room, except the superintendent's dining-room; no clerk's office, no visiting room for either males or females." Have the governors been reading Oliver Twist, and do they desire to relieve the difficulties of any little Oliver who may be called upon by Bumble to "bow to the Board" by providing the unmistakable hospitable board of the medical superintendent as the object of his salaam? And of course the friends of the patients can be excluded – such people are long suffering in Ireland, but what does the clerk do for an office? Does he work in a tent? By the way, we find no trace in this report of the circumstance with which a perplexed Irish superintendent used to convulse his English friends, when he assured them that his

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asylum buildings were so overcrowded that he had to place his patients under canvas. The tale has a ring of Harry Lorrequer, but such odd things happen in the distressful island that we actually gave it credit!

Again, kitchens and means of cooking appear to be generally inadequate. At Armagh we are told the kitchen is not "sufficiently large for the requirements of the institution," while "great difficulties exist in furnishing the extras, such as beef tea, for the use of the sick, and they have generally to be provided out of the medical superintendent's kitchen." Here a new cook is recommended, as well as a new kitchen. *Horresco referens*, but one cannot help hoping that the Board will not endeavour to combine the offices of cook and medical superintendent.

Reference

Fortieth Report of Inspectors of Lunatics in Ireland, January 1892, vol. 38.

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