columns

guidance in the Code reflects the qualification of autonomy for detained patients. It can also be applied to the additional reduction of autonomy, which may be experienced by the child patient, even if the child's legal status is informal. The Code reflects reality, tacitly acknowledging an abridgement of autonomy, which in certain circumstances will result in detention.

As the Code correctly summarises the law it is incorrect to state that it 'creates' inconsistencies (Parkin, *Psychiatric Bulletin*, October 1999, **23**, 887–889) or undermines the child's rights. All the Code does is highlight what may be regarded as the conflicts between the current law, current clinical practice and the child's human rights. This is the area where the debate needs to be focused. In particular whether the competent child's human rights have been infringed where a decision to override their treatment decisions has been made.

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Serotonin syndrome

Sir: Mir & Taylor (*Psychiatric Bulletin*, December 1999, **23**, 742–747) in their review of serotonin syndrome reminded us of the diagnostic criteria (Sternbach's criteria) for the diagnosis of this syndrome at a time when we had recently changed the drug therapy of a patient from trazodone to paroxetine. In this patient we saw the emergence of five symptoms listed in Sternbach's criteria (agitation, myoclonus, shivering, tremor and incoordination). We have two points to make: we noted that the most severe symptoms in this patient were nausea and vomiting. Although, it is accepted that nausea and vomiting may occur as part of the serotonin syndrome (Lane & Baldwin, 1997) they are not diagnostic criteria. Gastrointestinal symptoms are well-recognised effects of increased serotoninergic activity and it is surprising that there is little emphasis on them in the literature relating to this subject. Where serotonin syndrome is a result of changing drug therapy the possibility of a discontinuation syndrome should be considered as an alternative diagnosis because of the overlap in symptomatology between the two syndromes.

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Sir: It may be helpful for clinicians to appreciate that the great weight of recent evidence indicates that a spectrum model best explains serotonin syndrome phenomena. Serotonergic side-effects merge imperceptibly into 'toxic' effects or serotonin syndrome. Much confusion exists in the literature because in many reports an insufficiently precise distinction is being made between side-effects and toxicity.

At present the evidence is that life-threatening morbidity or mortality, only arises from combinations of monoamine oxidase inhibitors (this definitely does include so-called 'RIMAs' (reversible inhibitors of monoamine oxidase A) such as moclobemide) and drugs able to act as serotonin reuptake inhibitors (which includes some narcotic analgesics). The risk remains unclear for catechol-*O*-methyltransferase inhibitors.

I also wish to draw attention to some valuable prospectively gathered and systematically documented data specifically addressing the issues of what symptoms and signs characterise toxicity from various drugs when taken in overdose. These data come from Ian Whyte's group. In a series of over 5000 cases of self-poisoning 10% were with a single, primarily serotonergic, drug. Of these, 16% met the Sternbach criteria for serotonin syndrome.

The only serotonin reuptake inhibitor that was significantly different from the reference drug (sertraline) in its frequency of association with the serotonin syndrome was clomipramine, with which serotonin syndrome was only one-tenth as frequent (odds ratio 0.1 and 95% CI was 0.0–0.9). This may be because clomipramine is a potent 5-HT_{2A} antagonist.

Our extensive database of references about serotonin syndrome is available to researchers at www.psychotropical.com.

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Sir: Mir & Taylor (Psychiatric Bulletin, **23**, 742–747) make an error in their article on serotonin syndrome. They start their article by stating that serotonin syndrome appears to be a new phenomenon; this is untrue. Serotonin syndrome is well-known to be an element of the carcinoid syndrome, a medical disorder characterised by high levels of circulating catecholamines due to inappropriate secretion by a tumour, for example, of the gut or adrenal medulla. This is not a drug side-effect.

The implications of this are potentially serious; a patient could present with the symptoms described without having a drug-induced serotonin syndrome, and the differential diagnosis is not discussed in this paper. The sections on 'Causes of serotonin syndrome' and 'Biochemical mechanism of serotonin syndrome' are, therefore, dangerously misleading. This could result in missed diagnoses of carcinoid syndrome, or misattribution of systemic serotonergic effects because other causes have not been considered.

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College comments on the Fallon Inquiry

Sir: I refer to Dr Veasey's letter (*Psychiatric Bulletin*, November 1999, **13**, 690) asking who at the College was responsible for the College's comments on the Fallon Inquiry Report on Ashworth Hospital. I thought it appropriate to reply to Dr Veasey. I am now well briefed and informed about the controversy which gave him particular concern.

In this regard my information is that the College's response to the report on the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital (chaired by Judge Fallon) was first drafted by my predecessor Dr Robert Kendell and then finalised, following extensive discussion at the Executive and Finance Committee and then subsequently at Council on the 3 February 1999. I am sure that the intent was not to act in an unjust and unfair way against any individual psychiatrist. Let us hope, however, that structures are now in place which will make this fraught situation less likely to occur in the future.

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Martial arts for psychiatrists

Sir: Once a peer-reviewed article appears in a reputable journal it carries a certain cachet of validity, any editorial disclaimers

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