it is not all doom and gloom. As I tried to point out in my article, there are opportunities here to demand more resources. Of course psychiatry cannot be expected to be all things to all people, but every time an acute bed is blocked because of a lack of community facilities, or members of the multidisciplinary team cannot be accessed because of staff shortages, we are experiencing unmet need. The cry from the purchasing departments would be to stop complaining about it, and start measuring it.

Dr Travers' final point is that standing on the sidelines should always remain an option. I cannot agree with this. Like it or not, the NHS is changing and changing fast. Failure to engage in this process will not be without consequences.

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Publish or perish?

DEAR SIRS

The paper by Professor C. L. E. Katona and Dr M. M. Robertson (*Psychiatric Bulletin*, January 1993, **17**, 27–29) stresses the importance of published research as a predictor of success for trainees applying for senior registrar posts. It is a pity that the authors did not consider the number of attempts at passing both parts of the MRC Psych examination as one of the variables. Even though it can be argued that doing research helps passing exams, I suspect that many trainees would prefer to start their projects after obtaining the membership of the College, on the understanding that, important as research may be, passing the exams is a priority and the former would be of little promotional value without the latter. I have especially in mind those overseas trainees who are well aware of their extra handicaps, cultural and linguistic, when sitting exams in the UK and have preferred to concentrate on reading, revising and practising exam techniques at the expense of research time.

It is with certain dismay that we see the philosophy of "publish or perish" rapidly impregnating psychiatry training, and research activity is being perceived by many junior doctors more as an onerous prerequisite for achieving promotion than an exciting means of acquiring knowledge and developing a critical attitude and a capacity for organisation.

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Clozaril withdrawal syndrome

DEAR SIRS

We would like to report the possible development of withdrawal syndrome after prolonged use of Clozaril (clozapine), when stopped abruptly. This phenomenon has not been reported although rebound psychosis and supersensitivity psychosis are recognised as rare complications of this and other neuroleptic drugs. (Adams *et al* 1991; Kirkpatrick *et al*, 1992; Chouinard *et al*, 1978). The Clozaril drug data sheet suggest a gradual withdrawal except in the cases of drug induced blood dyscrasia when Clozaril needs to be stopped immediately.

Case report

A 31-year-old male chronic paranoid schizophrenic patient had two periods of Clozaril ingestion; the first period of 29 weeks (5 March to 28 September 1990) up to a maximum of 600 mgm daily and second period of 87 weeks after a gap of six weeks. He had up to a maximum of 500 mgm Clozaril daily (from 5 November 1990 until 9 July 1992). There were no withdrawal phenomena when Clozaril was stopped after the first period of ingestion due to status epilepticus. As he was showing only partial recovery, the clinical decision was made to tail off Clozaril 500 mgm over the next three days. He had no epileptic fit during the second period of ingestion while receiving 500 mgm of Clozaril. He had epileptic attacks while in receipt of 600 mgm of Clozaril which was clearly dose related. From 11 July 1992 for 12 days he suffered a withdrawal state partially controlled by restarting a much smaller dose of Clozaril, 50 mgm daily. The withdrawal symptoms were as tabled and consisted of the return of previous symptoms worsening of psychosis (delusions, hallucinations); resentful, abusive and the use of foul language; overactive behaviour) but also new symptoms agitation, restlessness; shakiness; dyskinesia; confusion; sweating; aggression; suicidal; (lying on the main road); insomnia). He was transferred to an acute admission ward for 16 days, and then went missing for three days when he slept rough.

This case clearly suggests development of a withdrawal syndrome after prolonged use of Clozaril, when stopped abruptly. Adams & Essali (1991) refer to the development of rebound psychosis, "racing thoughts to a distressing degree which settled in two weeks", but do not indicate whether this was new or the return of a previous symptom. Once the drug is stopped, which is supposed to suppress psychotic symptoms, there should be a rebound return of old symptoms. They also report the development of longer lasting "bizarrely psychotic with disturbing hallucinations" not settling after three months cessation of Clozaril (supersensitivity psychosis) suggesting, as described in relation to neuroleptics "a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms" (Chouinard *et al*, 1978). However, research has not established that chronic neuroleptic treatment causes this effect, and consideration of mechanisms has not been separated from causation (Kirkpatrick *et al*, 1992).

The case reported here of withdrawal syndrome cannot be diagnosed as supersensitivity psychosis (SSP) according to Chouinard's criteria (Chouinard & Jones, 1980). This has implications in the clinical management of those patients where Clozaril is

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