even with an electric current heavy enough to produce skin erythema. The technique would be unattractive with such problems, and in addition I fear that such low electrode placement over the eyes adds a risk of electric cataracts. According to Inglis (personal communication, 12 February 1973) a higher bi-frontal placement had been envisaged, reducing such risk. However, midline placement is more advantageous.

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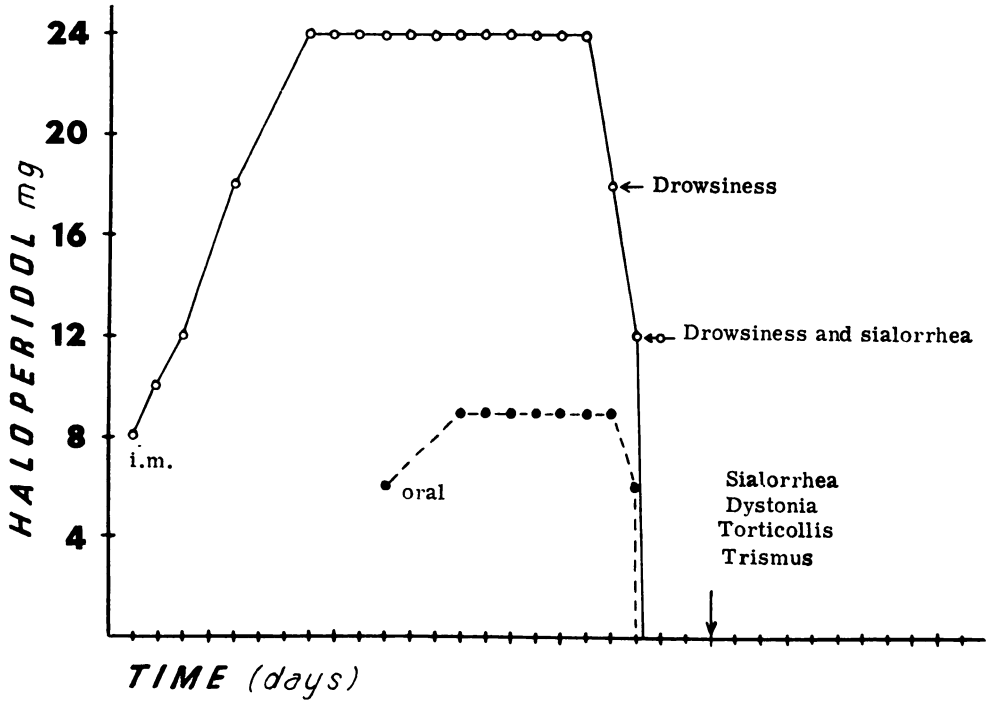
WITHDRAWAL SYNDROME AFTER NEUROLEPTICS

DEAR SIR,

In my Psychiatric Emergency Service we often receive severely disturbed patients necessitating large dosages of neuroleptics, chiefly chlorpromazine and haloperidol; and in several cases I have noticed the emergence of more or less important extrapyramidal and dystonic symptoms upon abrupt discontinuation of this medication. The following will exemplify. About a month ago we admitted a man aged 27 who presented with a mystic-religious delirium associated with vivid auditory hallucinations in the form of celestial music played on other-worldly instruments, whereby the patient felt that he was in contact with unearthly or extrasensory forces. In this frame, he had felt compelled to burn a pornographic book while holding it in his own hands—and had suffered severe burns in carrying out this 'command'. His IQ was 93; there was no evidence of mental deterioration. On 7 May we started treatment with haloperidol (8 mg. daily i.m.), later increasing the dosage to 24 mg. i.m. plus 8 mg. orally. In addition, the patient was given 100 mg. of chlorpromazine at night. No anti-parkinson drugs were used. This treatment alleviated the delirium and hallucination, and eventually these abated. On 25 May, while haloperidol was being withdrawn, the patient became somnolent; and two days later he developed severe sialorrhea without any evidence of parkinson-like or dystonic disorders. By that time neuroleptic therapy had been discontinued altogether. Two days later, in the absence of medication and with continuing sialorrhea, the patient developed a syndrome of linguo-bucco-facial dystonia, torticollis and trismus. These symptoms were partially controlled by repeated intravenous injections of diazepam, and abated in about three days, while the sialorrhea continued for another week and was still extant, though not severe, at discharge. Now, drowsiness is known to herald an extrapyramidal and dystonic syndrome in many cases (Delay and Deniker), and



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this is why we discontinued neuroleptic medication when it appeared in our patient; but this discontinuance was not enough to forestall the oncoming neurodysleptic syndrome.

While uncommon, the emergence of a parkinson-like syndrome after discontinuance of neuroleptic therapy is puzzling. Have there been any similar observations from other quarters? And should this occurrence be interpreted simply as a delayed effect, as a rebound effect, or as a true withdrawal syndrome?

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GILLES DE LA TOURETTE'S DISEASE

Dear Sir,

Dr. Friel (*Journal*, June 1973, **122**, 655–8) discusses the possible dopaminergic hyperactivity in the striatum of patients with Gilles de la Tourette's disease, concluding that it is a matter of speculation 'whether this hyperactivity is produced by enhanced release of dopamine, impaired inactivation of dopamine or hypersensitivity of the receptors'.

May I suggest a test which might help us to decide between these hypotheses? Lithium treatment appears to be effective in three disorders which are all thought to involve dopamine receptor supersensitivity in the striatum (1, 2): Huntington's disease (3, 4, 5), tardive dyskinesia (3, 6, 7), and the hyperkinetic phenomena induced by L-dopa in parkinsonism (8). There is so far no report on lithium treatment in Gilles de la Tourette's disease. If lithium should prove effective, the pathophysiology of this disorder would be linked to that of the other three mentioned, and receptor supersensitivity might be the common denominator.

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SERVICES IN THE COMMUNITY FOR THE MENTALLY ILL

Dear Sir,

I should like to reply to Dr. Burkitt's letter which appeared in the correspondence columns of the July issue of this *Journal* (pp. 131–2). May I mention first that I am Principal Medical Officer of Health and Community Psychiatrist for the London Borough of Haringey.

A number of psychiatrists, especially those involved in community psychiatric work have from time to time brought to the attention of the profession, the Department of Health and Social Security and even Members of Parliament, the present dichotomy between psychiatric workers in the community and those in hospital and referred not only to social workers and other psychiatric disciplines but also to psychiatrists themselves.

The Local Authority Social Services Act 1970 unfortunately initiated this split, and the contemplated legislation for the reorganized National Health Service seems to facilitate complete separation between the community and hospital psychiatric services.

I am given to understand, however, that it is still not too late to persist in making our views heard.

It is true that the proposed legislation mentions 'co-operation and liaison' between Local Authority Social Services Departments and the future Area Health Authorities, but any such 'arrangements' will only be permissive and tenuous and depend to a large extent upon the goodwill and sympathies of the respective people running the Local Authority Departments.

It must be emphasized that 'the decision to co-operate' rests with Local Authority officers and the legislation recommends that some of the Local Authority officers should become attached to the envisaged District Management and Health Care Planning Teams of the Health Authorities; yet no clear recommendations are made in reverse which