

DANGERS OF REDUCING LITHIUM

DEAR SIR,

We were interested but not surprised at the article and letter regarding the dangers of manic relapse following lithium withdrawal (*Journal*, October 1982, 141, 407–10, and 431). The existing literature regarding this known hazard made us concerned about the nature of the investigation undertaken by Drs Margo and McMahon and we looked in vain for an indication in their article that the patients involved in their study had given their informed consent.

More attention has been paid to the advisability of maintaining patients on long-term lithium treatment, particularly following the recent concern about the effect of lithium on renal structure and function. Three years ago we started a prospective investigation to determine whether patients maintained on lithium would remain well if their lithium levels were maintained below the (then) recommended minimum serum lithium level of 0.6 mmol/l. In an initial pilot study we reduced the lithium dosage in 29 patients suffering from affective disorder who had been maintained on lithium for a period of 1 to 12 years (mean = 6.7 years). Twenty-five patients suffered from bipolar affective illness, four were unipolar. These patients were part of 165 patients who regularly attended the New York University/Bellevue Center Affective Disorders Clinic and were selected on the basis of the patient's wish to reduce his lithium dosage (12 cases); the remaining 17 subjects had impaired renal concentration ability. All patients had remained free of affective episodes since starting lithium apart from one patient who had stopped lithium suddenly in the past and had become manic.

The dose of lithium was reduced so as to maintain a serum lithium level of between 0.3 and 0.7 mmol/l. The patients were seen at 2 weekly intervals for 2 months and then at monthly intervals if there was no sign of mood disturbance. Serum lithium levels were taken at each visit. All patients were taking lithium alone with no other psychotropic drug.

For direct comparison, all other patients in the clinic receiving lithium alone and who had been maintained on the drug without relapse for at least one year were studied as the control group. Forty eight patients fulfilled these criteria. These patients did not differ in the period of time during which they were receiving lithium, maintained serum lithium level, diagnosis, age or sex ratio, from the patients in whom the lithium dose was reduced. These patients continued to attend the lithium clinic at their customary frequency, which ranged from three-weekly to three-monthly intervals.

All patients were monitored for a period of six months. Patients who had an affective relapse, sufficient to warrant additional medication or change of

drug, and who scored 60 or less on the Global Assessment Scale were recorded as relapsed cases and treated appropriately.

Of the 29 patients in whom the dose of lithium was reduced 13 relapsed during the 6 month period of study. The mean time of relapse was 12.2 ± 7.4 weeks after lithium dosage was reduced (range 3–25 weeks). All the 11 bipolar patients who relapsed became manic whereas the 2 unipolar patients again became depressed. Two manic patients required admission to hospital. Six of the 48 patients in whom the lithium level was maintained relapsed, 4 of whom became depressed, including 2 bipolar subjects. These results indicate that dosage reduction was a significant factor in causing relapse ($P < 0.01$ χ^2 test with Yates' correction).

Attempts were made to determine whether it was the percentage reduction of dosage which contributed most to relapse, or reduction of lithium dosage below a critical lithium level. There was no significant relationship between either of these measures and likelihood of relapse but 2 patients relapsed even though their new maintained lithium level was as high as 0.7 mmol/l.

The results indicate that it may be hazardous to reduce the dose of lithium precipitously in bipolar patients maintained on lithium for long periods. Lower maintenance serum lithium levels may well be effective in maintaining prophylaxis (Hullin, 1980) but the incremental reduction in dosage should be kept as small as possible to minimize the chance of manic relapse.

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Reference

- HULLIN, R. P. (1980) Minimum serum lithium levels for effective prophylaxis. In *Handbook of Lithium Therapy*, (ed. F. N. Johnson), pp. 243–7. Lancaster: MTP Press.

COMMUNITY SCREENING FOR MENTAL ILLNESS

DEAR SIR,

The General Health Questionnaire is widely used for psychiatric screening and for comparing levels of distress in epidemiological research. The claim of Benjamin, Decalmer and Haran (*Journal*, February