

but this has not previously been reported in healthy young individuals. We report a case of sudden death during exercise in a fit 39-year-old male while undergoing antidepressant treatment.

Case report. The description of the mode of death of a fit 39-year-old male while out jogging was suggestive of acute cardiac failure. Post-mortem examination revealed no evidence of atherosclerosis or other conditions which together account for 94% of autopsy-proven causes of sudden natural death (Davies, 1989), and levels of medication were within therapeutic limits. There were no ECG abnormalities and, apart from a high degree of subjective distress, there were no risk factors for, or signs and symptoms of, ischaemic heart disease before commencing treatment with lofepramine (140 mg daily) and temazepam (10 mg nocte PRN) for a major depressive disorder (DSM-III-R). The patient had reported troublesome anticholinergic side effects and an episode of palpitations – unrelated to exercise – in his fourth week of treatment, following an increase in the dose of lofepramine to 210 mg daily, but physical examination 24 hours before his death revealed no abnormalities. A fatal arrhythmia (ventricular tachycardia which rapidly degenerated to ventricular fibrillation) was assumed. In the majority of cases, fatal arrhythmias are associated with myocardial infarction, and it was not possible to exclude an acute infarct, since post-mortem evidence may be lacking when death occurs rapidly. Lofepramine has not been associated with deaths in overdose (e.g. Cassidy & Henry, 1987) but has been associated with cardiac arrhythmias and sudden unexplained deaths in the United Kingdom (but not in healthy young individuals). Between 1982 and 1990 there were 23 reports of tachycardia, 14 of cardiac arrhythmia (2 deaths), two of non-fatal cardiac arrest, and four sudden deaths. On the basis of equivocal evidence, an open verdict was reached at inquest.

It is possible that antidepressants with anticholinergic side effects may have an indirect role in the evolution of sudden cardiac death (SCD) by depressing baroreflex sensitivity (BRS). The baroreflex results in a slowing of the heart rate in response to a rise in systolic blood pressure, and is therefore protective against the progression of tachyarrhythmias. It is known that the risk of SCD is greatly increased in patients with autonomic neuropathies affecting the vagal nerve, and it has been established, in canine models and post-infarction patients, that a depressed BRS (primarily reflecting an impairment in the vagal efferent component of the baroreflex) is associated with a greater susceptibility to ventricular fibrillation and subsequent SCD (e.g. Cripps & Camm, 1989).

CASSIDY, S. & HENRY, J. (1987) Fatal toxicity of antidepressant drugs in overdose. *British Medical Journal*, **295**, 1021–1024.

DAVIES, M. J. (1989) In *Current Approaches: Sudden Cardiac Death* (eds A. J. Camm, J. C. Malkin & M. L. Page). Southampton: Duphar Medical Relations.

CRIPPS, T. R. & CAMM, A. J. (1989) Prediction of arrhythmic events in patients following myocardial infarction. *Clinical Cardiology*, **12**, 661–665.

TONI LOCK

*University Department of Psychiatry
Royal Liverpool Hospital
Box 147
Liverpool L69 3BX*

WILLIAM KENYON

*Broadgreen Hospital
Liverpool*

M. T. ABOU-SALEH

*University Department of Psychiatry
Royal Liverpool Hospital*

Hair loss associated with fluoxetine

SIR: I would like to report a case of hair loss in a patient taking fluoxetine, which is rare.

Case report. Mrs A, a 72-year-old, married white woman with a one-year history of depression, met DSM-III-R criteria for major depression without psychotic features. Her symptoms included psychomotor retardation, slow low volume speech, poor energy level and sleep disturbance, but no suicidal ideation. She had no history before this event of any psychiatric disorder, including alcohol or drug abuse. Her laboratory tests, which included a total with differential blood count, liver function tests, electrolytes, thyroid function studies (T3, T4 and TSH), venereal disease research laboratory test (VDRL), and urine analysis, were within normal limits. She had received an adequate trial of nortriptyline and trazodone without success. A trial of fluoxetine (20 mg/day) was begun with her Hamilton Rating Scale for Depression (HRSD) score being 24 on a 21-item scale. She began noticing significant hair loss from the scalp within two weeks without any other dermatological problem. The fluoxetine was immediately discontinued, but she continued to lose scalp and body hair. A complete medical evaluation revealed no other cause for the hair loss. She was not taking other medications concomitantly, nor did she suffer from any significant ongoing medical problems. Her depression was treated successfully with electroconvulsive therapy, the HRSD score reducing to four. The hair loss continued, and at 18-month follow-up she remains without any scalp or body hair, but is doing well as far as depression is concerned.

We are aware of only one other case of severe hair loss with fluoxetine (Jenicke, 1991). As fluoxetine is a widely used antidepressant, these reports suggest that there might be a wide spectrum of hair loss, from obvious cases which come to medical attention to subtle ones which clinicians should look for.

JENICKE, M. A. (1991) Severe hair loss associated with fluoxetine use. *American Journal of Psychiatry*, **148**, 392.

SANJAY GUPTA

*Department of Psychiatry
The University of Iowa Hospitals and Clinics
550 Newton Road
Iowa City, Iowa 52242, USA*

LESLIE F. MAJOR

*SUNY Health Science Center
Binghamton
New York 13902-6000, USA*

CORRIGENDUM

Journal, September 1991, **159**, 441. (Motor disorder in severe mental handicap, paragraph 2). The references should read Kohen & Matthew (*Journal*, October 1990, **157**, 621; *Journal*, April 1991, **158**, 571).

A HUNDRED YEARS AGO

Mental work and physical exercise

Mr Ritchie's assertion at a recent meeting of the Victoria Park Cricket Association, that the national game still occupies in its season a place of due prominence in the minds of our busiest legislators, is one that neither he nor his hearers have need to be ashamed of. Supported by the existence of an annual match between the Lords and Commons, besides innumerable facts of less pretention which tell the same tale, it speaks well even for the mental quality of those who guide the councils of this country. The sound mind has no reliable connexion with any but the healthy body. Under ordinary conditions, no mere closet thinker, no mere debater, can long remain master of his full power of thought or of expression. Sooner or later he must tend to exhibit in himself what we may describe as a nervous specialism to become overstrained and oversensitive. The political representative, it must be remembered, is a man of affairs. As such he has no less need of plain and practical common sense than of sagacity, acumen, and skill in argument. As such, also, he is at all times open to the access of numberless worries. He is par-

ticularly liable to digestive derangements from this cause and from the want of regular bodily exertion. Naturally and rightly, therefore, he seeks and finds in physical exercise and in all that pertains thereto the means of reaching a sounder and a simpler life than that allowed in his daily round of duty. We may depend upon it that the man who thus mingles in his daily method the conditions needful for mental and for physical development will prove in the end the fitter for all those offices which bring him into daily contact with the ways, the wills, and the needs of his fellow-men in every class. In this he is not peculiar. What is true in his case applies to that of busy men in any calling which does not itself entail a heavy drain upon physical strength. Mental workers of every variety cannot do better than follow the same rule, and, after a well-known suggestion of Abernethy, seek in muscular work a relief which will usually be found from mental irritation and overstrain. A due regard for age and for moderation, of course, must be understood.

Reference

Lancet, 21 November 1891, 1179.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey.