but in elderly patients we have found more problems are created than are solved.

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Post-stroke rapid cycling bipolar affective disorder

SIR: Blackwell (*Journal*, August 1991, **159**, 279–280) reports the case of a young man who developed a rapid-cycling manic–depressive illness complicating a small brain stem haematoma. The following case report further illustrates the phenomenology of mood swings occurring in a patient who developed a very rapid-cycling affective disorder following a right hemisphere cerebrovascular accident.

Case report. The patient was a 44-year-old ambidextrous man who suffered an ischaemic infarct involving the right hemisphere (mainly temporo-insular and anterior parietal regions) that left him with a left hemiparesis and a left arm dystonia. He had a previous history of alcohol abuse but no positive family or personal history of affective disorder. Two months after his stroke, his wife noted that he began to experience abrupt changes in mood, even within a few hours, from jocularity to helplessness, and from talkativeness to elective mutism. Affective states were evaluated on repeated occasions using the Hamilton Rating Scale for Depression (HRSD) and the Mania Scale (MAS; Beck *et al*, 1986). During the manic phases he appeared distractible and elated, and joked inappropriately. At times he was irritable and occasionally exploded into a rage with only trivial precipitants. He also showed loud, pressured speech, flight of thoughts, and increased libido and activity. Through several manic episodes, his MAS score ranged from 13 (hypomania) to 18 points (definite mania). During depressive phases, he appeared apprehensive and forgetful, and showed a pessimistic attitude towards the future and total loss of libido. His HRSD scores were always above 16 points (major depression). It was noted that over a period of two weeks the patient had at least three mood swings per day. Bipolar cycles with intervening euthymic periods and very brief mixed affective states were also documented. The patient was started on treatment with carbamazepine (600 mg/day), but he developed intolerable side effects, and the medication was discontinued. Lithium carbonate was then prescribed but it was withdrawn because of non-compliance. Rapid cycling spontaneously subsided one year after onset.

The phenomenological profiles of post-stroke depression and mania are both remarkably similar to those found in patients with functional affective disorders (Starkstein & Robinson, 1989). Furthermore, seasonal patterns of bipolar illness (Hunt & Silverstone, 1990) and unipolar mania (Berthier *et al*, 1990) have been reported after focal involvement of the limbic system. The occurrence of very rapid mood fluctuations between mania and depression alternating every two weeks in Blackwell's patient and on an hour-by-hour basis in the present case also parallels that of functional rapid-cycling bipolar affective disorder (Wolpert *et al*, 1990). Focal damage to the limbic system affecting midline structures (Blackwell, 1991) or the right hemisphere might be implicated in the pathogenesis of rapid-cycling bipolar affective disorder.

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Fluvoxamine withdrawal syndrome

SIR: Fluvoxamine is a selective 5-hydroxytryptamine (5-HT) uptake inhibitor that has been shown to be effective in the treatment of obsessive–compulsive disorder (OCD) (Goodman *et al*, 1990). I report here a patient who developed a distinct psychiatric syndrome whenever she stopped her fluvoxamine medication.

Case report. The patient was a 30-year-old woman in 1987 when her medication with fluvoxamine was started. She had a long history of OCD; the illness started at age 12 with compulsive hand-washing and bathing. Over the years her symptoms fluctuated; although there were a couple of years of good functioning, she was usually severely incapacitated