Recognizing neuroleptic malignant syndrome

Geethan J. Chandran and associates, in their report of a case of neuroleptic malignant syndrome (NMS),[1] describe an 81-year-old man who was given 2 dopamine D_2 blocking agents, with a total daily dose roughly equivalent to 9 mg of haloperidol, a very high dosage for someone this age. Within 3 days, one of these drugs was stopped, but the dosage of the other was increased. Although we do not know exactly what causes NMS, high dosages, rapid dosage increases and polypharmacy are all too typical in the majority of reported cases.[2]

The neuroleptic medication was continued for another day, after the development of fever, autonomic instability, tremor, rigidity and elevated creatine kinase (CK). In our opinion, an appropriate standard of care would necessitate immediate discontinuation of all dopamine-blocking agents in probable or suspected cases of NMS.

We are also concerned that the authors reinitiated neuroleptic therapy (olanzapine) "a few days" after resolution of symptoms and normalization of the CK level, "because of its lower reported rate of NMS." Reintroduction of any dopamine-blocking agent within 2 weeks of an NMS episode places patients at immediate high risk of another episode.[3] There are now more than 36 published case reports of NMS precipitated by olanzapine (list available upon request), including one in which olanzapine triggered NMS in a patient with a history of 2 previous episodes.

Finally, the authors' statement that "treatment of NMS must be continued for 2–3 weeks until symptoms remit" is puzzling, given that NMS typically resolves in 5–7 days, longer only if depot dopamine-blocking agents have been used. In our experience (more than 50 cases, all with excellent outcomes), dantrolene and bromocriptine are unnecessary if neuroleptics are discontinued immediately and appropriate supportive care is provided.[4] Several reports[5] suggest that bromocriptine may prolong the syndrome.

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Discontinuation of benzodiazepines

The article by Lucie Baillargeon and associates[1] serves more to critique what is going on in medical practice than to contribute to medical knowledge. The use of benzodiazepines should be restricted to the treatment of status epilepticus;[2] because of their highly addictive nature, they should not be used for habitual sedation. Even the manufacturers caution against use of benzodiazepines in elderly patients or in combination with alcohol. In a health care system that is strapped for money, it is astounding that such profligate expenditure on bad medical practice is allowed and that resources are being used to support costly with-

drawal practices in a situation that should not have been initiated and supported in the first place. The publication of an article such as this one, upholstered with a sufficiency of the elegant though irrelevant algebra that so delights editors, may still do some good if it leads to action against bad medical practice and waste. Is nobody minding the shop?

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I commend Lucie Baillargeon and colleagues[1] for conducting their important and challenging study on discontinuation of benzodiazepine therapy in elderly patients. However, I have concerns about the control group, as described in the report. The physicians of patients whose benzodiazepines were gradually withdrawn in the control group "were not permitted to give advice on nonpharmacological treatments of insomnia."[1] Given the effectiveness of such interventions for chronic insomnia in older people,[2,3] it is not surprising that cognitive–behavioural therapy combined with drug tapering was found to be superior to benzodiazepine withdrawal alone. What this study does not establish is whether cognitive–behavioural therapy is better than standard care, which would include, at a minimum, advice on sleep hygiene.[2]

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Cat naps

Sheldon Singh and associates[1] conclude that their patient's symptoms of presyncope "may have been due to the weight of her cat on her right carotid sinus." However, they report that multiple pauses of 3–4 seconds' duration, associated with vomiting and syncope, were observed while the patient was in the emergency department, without the cat.[1]

Hypersensitive carotid sinus syndrome (as diagnosed in this patient) and severe sick sinus syndrome commonly occur together. The superiority of dual-chamber, atrially based pacing of these patients has been demonstrated in VVI (ventricular demand pacing) to DDD (fully automatic pacing) crossover studies.[2] In addition, the British Pacing and Electrophysiology Group has recommended selecting a pacing mode with as many features of normal sinus rhythm as possible,[3] and Moller and colleagues[4] demonstrated that prescribing relatively contraindicated[3] products for older patients represented a false economy.

In the case reported by Singh and associates,[1] a single-lead (ventricular) pacemaker was inserted. Thus, the patient would be wise to keep the cat off her neck in future because she has been given an inferior device, activation of which can sometimes be severely vasodepressive in patients with retrograde conduction. The statement by Singh and colleagues[1] that "cardiac pacing is … not [helpful] for those [patients] with vasodepressor response" relates primarily to use of ventricular pacing; in contrast, many patients with severe hypotensive syndromes can be rendered more or less asymptomatic if they are given a device with high-rate, dual-chamber pacing response to the associated sudden drops in heart rate.[5]

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Sustainability of health care in Canada

Morris Barer and colleagues[1] set out to "ascertain whether there is more than just rhetoric" behind claims that the Canadian health care system is unsustainable. Although their interpretation does not specifically confront this stated objective, they imply that the system is sustainable. I do not believe their data support this conclusion.

The authors' statement that "the combined effects of population growth, aging and general inflation . . . were virtually identical to the overall increase in physician expenditures"[1] is misleading. Physician fees declined by 9.4% in real terms during the years studied,[1] and fees were the only inflation-sensitive measure of the study. The increase in expenditures was therefore not an "effect" of inflation; rather, the effects of increased utilization were compensated for by the decline in real value of physician fees. Putting aside the important issue of whether this situation is equitable, it clearly is not sustainable: