

tradiol (0.1 mg topically every 3 days). She did not have any physical problems other than her neuralgia. As a result of neuralgia-induced pain, she was started on an oral regimen of tramadol, 50 mg q.i.d. During the next 6 days she began to experience constipation, confusion, depression, suicidal ideation with plans (but no intent), and paranoid thoughts. Although she experienced a multitude of symptoms, she cited the constipation as the reason for discontinuing tramadol treatment. The symptoms gradually disappeared over 3 days. She again started using tramadol and experienced symptoms of suicidal ideation, confusion, and memory problems. She began to feel hopeless and unable to care for herself. After 4 days she again decided to stop taking tramadol, and again her symptoms disappeared. She avoided using tramadol for 4 days but restarted treatment a third time because of the pain. Four days after resuming tramadol treatment she was seen by her mental health counselors. At that time her depression and suicidal ideation were of sufficient concern to warrant inpatient hospitalization. Her tramadol treatment was stopped, and 2 days after admission her symptoms cleared. She was discharged on the third day.

Although a causal relationship could not be determined, studies conducted by the manufacturer revealed that two of 429 subjects who had been using tramadol reported a "suicidal tendency" (personal communication, Ortho-McNeil Pharmaceutical Corporation, 1995). A possible tramadol-induced suicide has already been reported (3). The consistent temporal relationship of medication regimen to our patient's depression and resolution strongly suggests that tramadol precipitated alterations in her mood. The possibility of a drug-drug interaction cannot be ruled out. However, analgesics are frequently used with antidepressants, and estradiol is a commonly employed medication. We feel clinicians need to be aware that it is possible that patients who are taking tramadol may be at risk for depression and suicide.

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Critique of DSM-IV: Associated Features of Neuroleptic-Induced Parkinsonism

TO THE EDITOR: In the text that describes the associated behavioral symptoms of neuroleptic-induced parkinsonism, DSM-IV mentions inhibited blinking in response to glabella tapping.

This is incorrect. Neuroleptic-induced parkinsonism mimics and is clinically similar to Parkinson's disease (1). In both, there is an inability to inhibit blinking in response to a tap over the glabella (the bridge of the nose), which is known as Myerson's sign or the glabella reflex (2).

The reflex is elicited by tapping over the glabella with the

index finger. A normal individual will blink in response to each tap. After 6-8 taps, he or she will stop blinking in spite of continuous, repetitive tapping because of habituation (3). The patient with parkinsonism will continue to blink in response to each and every tap over the glabella, i.e., there is exaggerated blinking response to glabella tapping and no development of habituation (4). This exaggerated response is thought to be a part of hyperactive facial reflexes that occur generally in parkinsonism (5).

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"Smart Drugs": A Caution to Everybody

TO THE EDITOR: I am writing to acquaint my colleagues who may be unaware, as I was, about so-called "smart drugs." These are not necessarily vitamins or other dietary supplements but can be pharmaceuticals that are available in this country only by prescription. These drugs are advertised in books that can be found in any bookstore (1). The medications, which include phenytoin, hydroxyzine, thyroid hormone, vasopressin, propranolol, procaine, and L-dopa, are being promoted to increase intelligence and mental energy. While the books do say that one can (and sometimes should) obtain these drugs from a physician, they also say that most physicians will not prescribe the medications for these way-off-label uses. Thus, mail order resources, advertising newsletters, and lists of physicians who are willing to prescribe these drugs are included in the back of the books.

I became aware of smart drugs when one of my patients, who had very recently started taking a low dose of a selective serotonin reuptake inhibitor (SSRI), called to say he was having peculiar symptoms. He was concerned because he had a job interview the next day. He wondered if he was having a reaction to the SSRI. His symptoms sounded like a mild variant of the serotonergic syndrome, which made no sense because he had told me he was taking no other medications.

After further questioning, he told me that to get himself in prime shape for the interview he had taken a cocktail of smart drugs that morning—one of which was selegiline, an irreversible monoamine oxidase inhibitor that he had taken in a therapeutic dose of 5 mg. Another was piracetam, a mild psychostimulant. He had obtained both of these medications by mail order from a source he had found listed in the back of a book on smart drugs. He had not thought to tell me about using these drugs, since he considered them harmless because he had not needed a doctor's prescription to obtain them.

I urge all of my colleagues to familiarize themselves with smart drugs and to routinely ask about them in their practices. A browse in the health aisles at the local bookstore is very enlightening indeed, and sending away for a list of medications and prices is even more so.

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Gambling in Minnesota

TO THE EDITOR: Over the last several years, Minnesota has experienced a drastic increase in the number of gambling sites, largely (but not entirely) because of legalized gambling on Indian reservations. In the last year, the number of gamblers was estimated by the state of Minnesota to be 1.5 million (out of 4.5 million people), and the amount of money being gambled was estimated to be \$5.0–\$5.5 billion annually. An unpublished state survey indicated that as many as 45,000 Minnesotans are currently “pathological gamblers,” which is about 1% of the state population. In the last 1½ years, 845 patients have entered the six gambling treatment programs in the state at a cost of \$2,700–\$4,000 per individual. Minnesota is now second only to New Jersey and Nevada in the per capita funds spent on gambling.

Here at the Minneapolis Veterans Administration Medical Center, we have begun to encounter patients with gambling-related problems. Often these problems are revealed only after the patient has failed in treatment for another condition. In order to assess the extent of this problem, our service undertook a survey that used the South Oaks Gambling Screen that was developed by psychiatrist Dr. Sheila Blume. We screened 412 consecutive patients over a period of several weeks; all subjects provided written informed consent. Subjects were classified as having no gambling problem, mild gambling problems, or a pathological gambling problem.

Among 201 patients in the general psychiatry unit, 57 (28%) were classified as mild and 24 (12%) were classified as pathological gamblers. In this unit were 78 new outpatients (23 [30%] with mild and 14 [18%] with pathological gambling problems); 71 clinic outpatients (19 [27%] with mild and nine [13%] with pathological gambling problems); and 52 inpatients (15 [29%] with mild and one [2%] with pathological gambling problems).

Among 211 patients in the alcoholism-addictions unit, 48 (23%) were classified as mild, and 36 (17%) were classified as pathological gamblers. The unit consisted of 88 medically ill alcoholics (four [4%] with mild and 22 [25%] with pathological gambling problems); 49 evening/day patients (12 [24%] with mild and eight [16%] with pathological gambling problems); 35 outpatients (14 [40%] with mild and four [11%] with pathological gambling problems); and 39 alcohol/drug inpatients (18 [46%] with mild and two [5%] with pathological gambling problems).

For all 412 patients in the general psychiatry and alcoholism-addictions units, 247 (60%) had no gambling problem, but 105 (25%) and 60 (15%) of the patients had mild and pathological gambling problems, respectively.

The overall rate of pathological gambling among our patients was about 10 times the estimated rate for the general population of the state. Unexpectedly, the proportion among our patients with substance-related disorders and the proportion among our other psychiatric patients was almost identical, although programs within each area showed considerable diversity. We were surprised to find that the rate of pathological gambling was lowest among our inpatients, although high rates of mild gambling problems occurred even in this group.

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Predicting Inpatient Violence

TO THE EDITOR: In their generally excellent study, Dale E. McNeil, Ph.D., and Renée L. Binder, M.D., open the Discussion section with a statement that deserves some amplification: “These findings suggest that while clinicians can accurately classify the majority of patients at admission in terms of their likelihood of physically assaulting others during the first week of hospitalization, systematic errors characterize inaccurate assessments of risk of violence” (1).

Examination of the footnote to their table shows that the clinicians were accurate in a majority only of negative predictions. The positive predictions were right, as has so often been reported before, in less than 30% of cases (24 true positive and 59 false positive predictions, accuracy=28.9%; 131 true negative and 12 false negative predictions, accuracy=91.6%).

This is one more example of how difficult it is to predict low base rate phenomena (2). It speaks to the importance of discussing accuracy of positive and negative predictions separately. Although many psychiatrists who work in this area, myself included, believe we can predict violence in a useful way, it is important to keep in mind that research in this area consistently shows that we are very often wrong in individual cases.

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Drs. McNeil and Binder Reply

TO THE EDITOR: Dr. Beck suggests the need for amplification of our statement that, while clinicians can classify the majority of patients at admission in terms of short-term risk of violence, systematic errors characterize inaccurate assessments of violence potential. In our study, the total predictive power of clinicians' estimates of violence risk was 69% (24 true positive predictions plus 131 true negative predictions divided by 226 total subjects=0.69). Thus, the overall likelihood of clinicians' estimates of low or high risk being correct was 69%.

A central goal of our study was to understand factors that