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Smoking and Response to Psychotropic Drugs

To the Editor: The article by Hymowitz and associates (1) on cigarette smoking by patients with mental retardation and mental illness in the January 1997 issue was clinically quite useful.

As the authors appropriately point out, the prevalence of cigarette smoking among adults with mental illness is higher than the mean prevalence in the U.S. population, which was 23 percent in 1995. Smokers are indeed a cohort distinct from nonsmokers in many ways, such as dietary preferences and lifestyle habits.

Compared with nonsmokers, smokers tend to consume more coffee, alcohol, and meat (2). Smokers eat less fruit, vegetables, and dietary fiber and take fewer vitamin supplements than nonsmokers (3). Smokers also tend to exercise less and to get less sleep than similar nonsmokers (4). Smokers are also distinguished from their nonsmoking counterparts by demographic differences, such as economic status, level of education, and occupation.

It is also very important for clinicians to be aware that drug response differs in smokers compared with nonsmokers. Drugs that are primarily metabolized by P4501A2, the isozyme induced by cigarette smoke, include theophylline, tacrine, caffeine, clozapine, and phenacetin. As a result of cigarette smoke's enzyme-induction effect, the plasma concentration of these drugs in smokers is

typically lower than in similar nonsmokers.

Investigators have also found that smokers require a larger dose of neuroleptic drugs than do nonsmokers. In a double-blind study of 83 psychiatric inpatients receiving neuroleptic drugs at the Psychiatric Hospital of Prague, Vinarova and associates (5) found that male smokers (but not female smokers) typically required a larger dose relative to similar male nonsmokers. The average dose of chlorpromazine for male smokers was 510 mg compared with 248 mg for nonsmokers ($p < .04$). Neuroleptic drugs, however, are not metabolized primarily by the P4501A2 isozyme; therefore, another mechanism is predominately responsible.

Noting the effect that cigarette smoke has on patients' drug response—particularly in high-risk populations—can be a tremendous aid to clinicians who are trying to reduce the variability of drug therapy.

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Recidivism in Slovenia

To the Editor: Recidivism is still a major problem in psychiatry. The increase in hospital readmission rates

is usually ascribed to shorter inpatient stays. Most studies of recidivism have included patients from several diagnostic groups on the assumption that predictors of recidivism are the same for all diagnoses.

However, a study by Appleby and colleagues (1) focused on patients with schizophrenia. Like almost all other studies, it was done in a country with well-developed community care. An established aftercare system reduces recidivism (2), but it may mask the influence of other characteristics on recidivism. The predictors of recidivism may be different in East European or Third World countries where, in general, community care is poorly developed.

Slovenia has well-developed hospital and outpatient services, but other extrahospital services are still scarce. The aim of our study was to find the predictors of readmission for patients with schizophrenia who were treated in the department of psychiatry of the Medical Center in Ljubljana, a university-affiliated psychiatric hospital. The only psychiatric hospital in the region, it serves a catchment area of approximately 750,000 inhabitants, one-third of the population of Slovenia.

The study included 381 white patients (191 males and 190 females) with a diagnosis of schizophrenia according to the *International Classification of Diseases, Tenth Revision*. These patients, discharged in 1994, were followed up for 12 months. The patients' medical records provided data on age at first hospital admission, employment, domicile, marital status, important persons in the patient's life, life events, substance abuse, somatic illnesses, number of readmissions, and length of stay.

At admission and discharge all patients were interviewed using the Present State Examination, which provides information on the patient's symptoms at the time of the interview, and the Krawiecka Scale (3), which rates positive, negative, and affective symptoms. The Cox regression model and ordinal logit regression were used to study the influ-