Enuresis and Bell Alarms

SIR,—Drs. W. I. Forsythe and A. Redmond (24 January, p. 211) argue strongly in favour of the electric alarm method of treatment, but dismiss drug treatment as unsuccessful. I note that each of their 200 patients received "a course of drug therapy and treatment with the alarm bell" before undergoing x-ray investigation. No mention is made of the drugs used, their dosage, and the duration of the course, though I suspect that it was short and perhaps given less enthusiastically than the conditioning treatment.

In this area alarm sets are issued via the local authority and hospital clinics, and there is a considerable waiting list for these appliances. I have used drug treatment in those children awaiting an alarm set and have found amitriptyline and imipramine useful agents. When given initially at night, and later by day also, a dosage of the order of 25-75 mg. daily has often promoted prolonged periods of dryness, though I hesitate to label any of my patients as "cured." However, no child has been observed for more than two-and-a-half years and recently, one boy who had been dry for two years relapsed and has restarted drug treatment.—I am, etc.,

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Tetrabenazine for Extra-pyramidal Movement Disorders

SIR,—The majority of movement disorders of extra-pyramidal origin arising from the use of phenothiazines in schizophrenia are treated successfully by "anti-Parkinsonian" drugs, but a few distressing cases of what appear to be a more permanent disability have arisen with all the phenothiazines including the intramuscular preparations.^{1,2} I have had two patients whose symptoms were distressing and refractory to "recognized" anti-Parkinsonian agents, but both responded to tetrabenazine which was tried as a result of studying the paper by Dr. M. A. Dalby (17 May, p. 422).

A 60-year-old woman admitted to hospital two years ago had many bizarre delusions including one that she was having to contain the motions of all her near relatives, and because of this she had for 20 years visited the toilet many times each day. Her schizophrenic illness responded only to fluphenazine enanthate (intramuscular). For a few months unwanted effects were curtailed by anti-Parkinsonian drugs. However, over the months increasingly large doses of these became ineffective. Fluphenazine was stopped in April 1969. Her facial appearance showed grotesque distortions and also there was marked torsion dystonia of mainly the upper limbs. There were repeated "fly catching" dystonic outward jerks of her tongue, etc. She was started on tetrabenazine 50 mg. four times daily. Within 24 hours the abnormal movements had stopped completely, and on a maintenance dosage at home for the past 10 months (50 mg. t.d.s.) she remains perfectly well from both psychiatric and neurological viewpoints.

A 45-year-old woman, who had been a hospitalized chronic schizophrenic patient for 15 years, received her first (and only) fluphenazine in intramuscular enanthate form (12.5 mg.) on 8 February 1968. She had been really unremittingly psychotic since her first hospitalization at the age of 24 years, having shown no real

response to deep insulin therapy, E.C.T., leucotomy (in 1956), and all the tranquillizers when produced. The fluphenazine was given when she was in a negativistic state in which she had been refusing oral medication and most of her meals for several days, and showed aggressive and destructive tendencies. It resulted in improvement in her mental state, but marked akathisia, pirouetting, and dystonic and chorea-athetoid movements of her limbs occurred rapidly. No "ordinary" anti-Parkinsonian drug was of the slightest avail. Tetrabenazine 50 mg. t.d.s. was commenced on 20 May 1968. In less than 24 hours her abnormal movements had ceased entirely and she remains entirely well neurologically on this dosage.

Dalby treated 30 patients with various extra-pyramidal movement disorders and found it most useful in patients with choreiform and hemiballistic motor activity. My cases differ from his in being drug-induced by phenothiazines and with symptom-emphasis on dystonic movements, yet the treatment is equally successful. In view of Dalby's findings and those recorded here, one wonders just how widely tetrabenazine has been tried, especially as the drug firm stopped manufacturing it about five years ago. I have been using old stock left over from 10 years ago, when as a reserpine type drug it was used for schizophrenia *per se*. It may well be an alternative in some cases to the scarce and expensive L-dopa.—I am, etc.,

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REFERENCES

- 1 Kennedy, P. F., *British Journal of Psychiatry*, 1969, 115, 103.
- 2 Lowther, J., *British Journal of Psychiatry*, 1969, 115, 691.
- 3 Pryce, I. G., and Edwards, H., *British Journal of Psychiatry*, 1966, 112, 983.

Open Electrocardiograph Service

SIR,—Dr. D. S. Short (14 February, p. 433) is correct in saying that our paper (3 January, p. 41) is not designed to assess the accuracy of electrocardiographic diagnosis. However it is invalid to state that in an electrocardiograph referral service the diagnosis of coronary disease is based mainly on an interpretation of the electrocardiogram. Family doctors tend to have a healthy scepticism of special investigations and are likely to interpret the cardiogram report in the light of clinical findings. If it is considered that the family doctor is unqualified for the task of assessing chest pain and lacking in knowledge of the diagnostic limitations of the electrocardiogram, then it might be more practical to improve training of doctors rather than accept that such patients must be seen by a cardiologist. Certainly periodic courses for those using an open electrocardiograph service would seem to be worth while.

In general, the more investigations available to the family doctor the better is the

service that he can give his patients. Clearly many investigations must remain in the realm of the specialist, but we disagree with Dr. Short in that we do not consider the reported standard electrocardiogram to be one of these. Perhaps an open x-ray department is a particularly close parallel to the service we describe. Just as a normal electrocardiogram does not rule out a recent myocardial infarction, so a normal chest x-ray does not rule out the presence of a bronchial neoplasm, while non-specific abnormalities in both investigations are open to wide differences of interpretation.

Finally, the open electrocardiograph service in no way precludes the doctor sending a patient for a consultant opinion for diagnostic or other reasons.—We are, etc.,

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Chemotherapy of Bronchitis

SIR,—In a recent leading article on chemotherapy of bronchitis (17 January, p. 125) it was stated that increasing numbers of pneumococci and occasional strains of *Haemophilus influenzae* are now resistant to tetracycline, but that both these organisms are still sensitive to ampicillin.

This last statement should be treated with reserve. In a series of 22 strains of *H. influenzae* recently tested here, one was completely resistant to 5 µg. ampicillin per ml. and grew right up to a 2.0 µg. disc; two further strains showed partial growth to 5 µg./ml. and gave only partial inhibition round the disc. These figures should be compared with a minimum inhibitory concentration of 0.3 µg./ml. for most strains of *H. influenzae* with a zone of inhibition of 5 to 7 mm. and a minimum inhibitory concentration of 0.07 µg./ml. for the standard Oxford H strain of staphylococcus with a zone of inhibition of 9 mm.

The strain resistant to 5.0 µg. ampicillin per ml. was isolated from a girl with mucoviscidosis and bronchiectasis who had received a number of courses of ampicillin therapy. One of the partially resistant strains was isolated from a patient with chronic bronchitis; he may have received ampicillin but there is no record available. The other strain, from the National Collection of Type Cultures, was isolated in 1935 by Sir Alexander Fleming. It is therefore clear that there are a few strains of *H. influenzae* that are wholly or partially resistant to ampicillin.—I am, etc.,

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How Many Doctors?

SIR,—Mr. J. Shipman's letter (7 March, p. 633) draws attention to the neglected subject of the enormous increase in the number of doctors after 1975 recommended by the Royal Commission on Medical Edu-

cation.¹ He rightly stresses the impracticable nature of the exponential expansion in the doctor-population ratio proposed by the Royal Commission.

In the article² to which Mr. Shipman