MEDICAL PRACTICE

Today's Treatment

Psychological Medicine

Psychotropic Drugs in General Practice

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Earlier articles in this series have examined the indications for prescribing in a wide range of diseases and for defined problems in the hospital setting and in general practice. They have highlighted the side effects of most relevance to the patient and to try to repeat or even summarize this information would be regarded as unnecessary. My intention is to focus on three selected topics, each of which has a broader relevance to prescribing in general practice than might appear on the surface. These are: the variation in use of different hypnotic preparations by general practitioners; the range of the individual doctor's pharmacopoeia; and the hidden risks of prescribing psychotropic drugs. But before discussing these topics a brief consideration of some of the implications of the widely different published estimates of the incidence of psychological illness in patients consulting general practitioners is necessary. Psychological illness is usually reported as the cause of approximately 5% of consultations in general practice. This figure is, however, an average of many widely divergent figures. Shepherd *et al.* have shown that individual doctors may attribute up to half of their consultations to psychological illness.¹ Some of this difference is due to prevalent psychosocial factors or aspects of the doctor's personality as seen by his patients, but a large variation remains which appears to reflect different doctors' perceptions of whether the nature of the illnesses is principally physical or psychological.

The issues discussed in this article are not the doctor's ability to recognize the non-physical elements of illness but

the decisions on prescribing he takes on the assumption that appropriate diagnoses have been reached.

For example, in the section below on the use of different hypnotic preparations it is assumed that the patient's illness has been correctly diagnosed as justifying prescription of the group of psychotropic drugs under discussion.

Variation in Use of Hypnotic Drugs

Though the number of prescriptions for hypnotic drugs has remained constant over the last six years (see table I) there has been a steady change in the nature of these prescriptions. The benzodiazepine hypnotics (most notably Mogadon, nitrazepam),

TABLE I—*Changing Ratio of Prescriptions of Barbiturate: Benzodiazepine Hypnotics during 1968-73*

Year	Total Prescriptions for Hypnotics (millions)	Barbiturate to Benzodiazepine Ratio
1968	18.9	9.7:1
1969	18.0	6.9:1
1970	18.2	4.8:1
1971	17.9	2.9:1
1972	17.3	1.9:1
1973	18.1	1.5:1

which have proved safe and appear acceptable to most patients, have gained a steadily increasing share of the barbiturate market. (The figures in table I exclude prescriptions for phenobarbitone, which commonly relate to the treatment of epilepsy.) Yet the challenging feature is not the overall trend but the way in which the trend obscures extremes of policy between individual doctors. Examination of prescriptions for hypnotic drugs issued by 20 doctors over a period of one month showed that one doctor used only barbiturates whereas three used only

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nitrazepam; the other 16 doctors filled the middle ground, ranging from the use of barbiturates five times as often as nitrazepam to the reverse ratio. Wells² has shown that a practice policy of change from barbiturate to non-barbiturate can be effectively and humanely carried through. If a new drug has demonstrable benefits and no major disadvantages when compared with an established one, what should the general practitioner's attitude as prescriber be? The patient's preference cannot be ignored, but should patients be made to try the "better" alternative? It is surely wholly commendable to be cautious in prescribing new drugs until the balance of risk versus benefit has been clearly evaluated, but how much pressure should thereafter be placed on the non-conformist to justify his position? Sooner or later the profession must face the need to answer this difficult question over a wide field of activities. Discussion of the use of different hypnotic drugs might be an appropriate place to start.

The Individual Doctor's Pharmacopoeia

The drugs prescribed by a general practitioner may have been initiated from many sources other than that doctor. Partners, trainees, locums, and colleagues on rota duty are other sources within general practice, and recommendations on discharge from outpatient or inpatient hospital care are the rule rather than the exception. Patients move from practice to practice on established medication and usually expect this to be continued. In addition patients suggest remedies prescribed for their neighbours. How many drugs relating to one group of illnesses can a general practitioner be expected to be familiar with? What steps can be taken to effect a reduction in the number of drugs used in a practice against the normal policy of the principals in partnership?

In a two-doctor dispensing practice of 3000 patients a detailed analysis of the psychotropic drugs prescribed showed that, of 40 different preparations used, 23 had been prescribed less often than once each month, and 14 of these 23 preparations had been prescribed less than three times in the complete year of the study.³ Only eight preparations were used regularly, and practice policy decided at that time (1970) to attempt to discontinue the use of one of these eight (Mandrax, diphenhydramine plus methaqualone) and as many as possible of the 23 infrequently used preparations, many of which were being prescribed for negative rather than positive reasons. Reassessment of the use of psychotropic drugs in the same practice three years later⁴ showed that all but one patient had been taken off Mandrax but that only three of the 23 infrequently used preparations had left the list. This shows that even in a well-organized practice run by prescription-conscious doctors anxious to achieve a reduction in the variety of psychotropic drugs used very little change has resulted.

But a reduction in the number of essentially similar psychotropic drugs available on prescription might well benefit patients by making us examine fundamentally different approaches to therapy when one of more psychotropic agents have failed to help. In addition doctors might realistically hope to master the necessary working knowledge of the properties of the preparations for which they sign on E.C. 10 forms.

Hidden Risks

Most of the psychotropic drugs in common use have some well-known side effects. Barbiturates cause dependence and depression; chlorpromazine may cause jaundice; tricyclic antidepressants may produce unacceptable atropine-like side effects and cardiac arrhythmia, and have been associated with sudden death in patients with established ischaemic heart disease; the benzodiazepines appear relatively non-toxic but also may produce "hangover" and dependence.

The latest worry is the possibility of interaction between

drugs being used simultaneously. Many different modes of interaction have been recognized in theory, and a substantial number are relevant to clinical practice. Most psychotropic drugs interfere with the rate at which other drugs are metabolized, and this may lead either to prolonging or to reducing the effect of other drugs in use at the same time.

Some other combinations of drugs may interact because of competing metabolic pathways (tricyclic antidepressants and adrenergic neurone-blocking hypertensive agents) to produce unpredicted clinical results. Again drugs and foods may interact, as do the monoamine-oxidase inhibitors with tyramine-containing foods (initially noted with cheese). Caution in prescribing drugs simultaneously can only be a virtue, and very few doctors either in hospital or general practice carry the knowledge of pharmacology necessary to predict safe and unsafe combinations. Though some of the warnings given on interaction have been of theoretical rather than clinical relevance, the risks are now more widely recognized.

But a further risk exists. Doctors may prescribe combined preparations without appreciating that drugs with a potential to interact are included in the formulation. The risk may be made clearer by an example. The risk of bleeding when barbiturates are *withdrawn* from patients on anticoagulants is appreciated by around half the doctors in general practice.⁵ But do all doctors realize that all 33 drugs listed in table II contain barbiturates and that their inconstant use in patients on anticoagulants may make stabilization of dosage difficult?

TABLE II—Some Barbiturate-containing Proprietary Preparations

Actonorm	Franol
Aludrox SA	Heptonal
Aluhyde	Hypercal B
Alupent Sed	Hypertane co.
Amesec	Hyperysin
Asmacort	Neutradonna Sed
Asmal	Paminal
APP	Peptacol
Belladenal	Salimed co.
Beplete	Seominal
Calcidrine	Sonalgin
Daprisal	Sol-Tercin
Dolalgin	Spastipax
Doloxylal	Tedral
Donnatal	Tercin
Efamyl	Theominal
	Veriloid VP

Most doctors will argue—and reasonably—that they use only one or two drugs on this list and need know the constituents only of these. But will all doctors prescribing anticoagulants to these patients or other drugs to patients on anticoagulants always have accurate information on the current medication of the individual patient available? The honest answer is No, and the simple message is that polypharmacy must always increase the risks of iatrogenic disorders. In the field of psychotropic prescribing the risks of this are real.

Personal Prescribing Policy

My personal prescribing policies are based on the principles implied in the foregoing sections. Unfortunately, in practice these principles are too often overridden by the pressures and prejudices to which we are all exposed at each consultation. As a rule I initiate treatment with only a small number of psychotropic drugs. Usually diazepam (anxiety), amitriptyline (depression), doxepin (when uncertainty of the balance between anxiety and depression is present), and nitrazepam (hypnotic) meet most requirements. I have tended to allow patients who are satisfied with existing barbiturate hypnotics to continue on these and to avoid multiple prescribing, especially to patients on anticoagulant or hypertensive therapy. I have yet to prescribe any drug in the monoamine oxidase inhibitor group and rarely feel the use of appetite suppressants to be justified.

Conclusions

It is understandable that more debate has been given to *whether or not* psychotropic drugs should be prescribed than to *which* psychotropic drugs should be prescribed. I believe that both debates would be assisted by a smaller range of preparations being available for prescription.

Patients would receive drugs more familiar to the doctor, which must reduce side effects and inappropriate medication. Would there be an equal disadvantage in depriving patients of

the existing selection of drugs? The question deserves critical examination.

References

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Clinical Review

Patterns of Incidence in Acute Pancreatitis

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Summary

A review of acute pancreatitis occurring over a 20-year period in the Bristol clinical area is reported. A total of 590 cases were available for analysis. The yearly incidence was 53.8 per million population at risk, with a mortality of 9.0 per million. This compares favourably with 11.4 deaths per million for England and Wales as a whole during the same period but the difference is not statistically significant. When the deaths occurring in the Bristol clinical area were expressed in terms of case mortality rate the figure was 17%. In contrast the mortality for recurrent acute pancreatitis was only 1.5%, and the benign nature of this second condition is confirmed. Aetiological factors and age and sex distribution were also analysed in relation to each other and to mortality. An increase in acute pancreatitis secondary to chronic alcoholism was confirmed and steroid pancreatitis also emerged as a definite entity in this survey. The pattern of recurrence in patients with idiopathic pancreatitis was studied in detail and is analysed on an actuarial basis.

Introduction

The full pattern of the incidence of acute pancreatitis is hard to determine. Though large series of cases have been reported from many centres in different parts of the world most have been concerned with the disease as it occurs in selected segments of the population. Reports from special clinics in the United States have been on patients referred from a wide area, and the city hospital patients may have related to some large urban conurbation, but these centres serve only low-income groups.

Furthermore, the Veterans Hospitals, the other source of large series of cases in the United States, also represent a highly selected section of the population. In the same way, incidence and mortality statistics from other parts of the world have always been derived from hospital case series and it is never clear how closely they relate to the disease as it occurs in the general population. There has been only one report of a population survey.¹ This was undertaken in Rochester, Minnesota, and though some of the details, particularly of the follow-up and checking procedures, were scanty it provided the first geographical yearly incidence for all forms of the disease ranging from 150 to 180 cases per million population. For acute pancreatitis alone (but including recurrent acute pancreatitis) the yearly incidence ranged from 100 to 115 cases per million.

We present an analysis of all cases of acute pancreatitis occurring in the Bristol clinical area during the 20-year period 1950-69. The patients were drawn from the large urban area of the city of Bristol and its suburbs and from the rural area of south Gloucestershire and north Somerset.

Clinical Material

In collecting the cases a most careful search was made in all the hospitals in the Bristol area. Details of the few cases treated in private hospitals were also kindly supplied by the consultants concerned, and these figures were then checked, firstly, by reference to the regional hospital board's hospital activity analysis system and then by examination of the cases certified as dying from the disease during the period. In this connexion detailed reports of the coroners' necropsies were obtained. Interestingly, the regional hospital board's statistics and the coroners' data consistently produced one or two cases of acute pancreatitis each year not identified from the other sources.

The diagnostic criteria were either a consistent clinical picture and a serum amylase level over 1000 Somogyi units or acute pancreatitis plainly evident at laparotomy or necropsy. On the basis of these criteria and from the search outlined 590 primary attacks were identified over the 20-year period. There was no significant referral rate of patients with pancreatitis from outside the area and thus the series seemed to be fully representative of the disease pattern in the area at that time.

Because the hospital activities analysis data and coroners'

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