months resulted in early and continued overall improvement. The stools became firmer and the frequency reduced to two or three a day. There was relief of the abdominal pain and discomfort. His weight has remained constant at 8½st. (55 kg.). He has been maintained for 11 months on one tablet t.d.s. with no evidence of tolerance developing, and now has returned to his normal work as a garage mechanic.

My thanks to Dr. B. Cream and his unit at St. Thomas's Hospital for their investigation of this case.—I am, etc.,

J. A. B. WESTON.

Chertsey, Surrey.

REFERENCE

1 Gorbach, S. L., *et al.*, *Lancet*, 1969, 1, 74.

## Action on Amphetamines

SIR,—The Ilkeston Hospitals' Medical Staff Advisory Committee, including in its membership all the general practitioners in the town of Ilkeston, at a recent meeting recommended that there should be a total ban on the prescription of amphetamine and its analogues.

The committee took this action in the light of the many break-ins of chemists' premises in the town in recent months, where amphetamine has been one of the main targets of the raids. Its members are aware that lack of prescription will result in the chemists ceasing to stock the drugs, with the end result that the uncontrolled use of the drug will be diminished, if not eliminated.

While this action has been taken because of the local situation the committee recommend a similar voluntary action by doctors elsewhere to combat the problems created by the use of this particular drug, especially among young persons [see also *B.M.J.* 8 May, p. 361].—I am, etc.,

T. H. GILLISON,
Chairman,
Medical Staff Committee.

Ilkeston General Hospital,
Ilkeston, Derbyshire.

## Fluphenazine Enanthate in Schizophrenia

SIR,—The use of fluphenazine enanthate[1-3] and more recently decanoate in schizophrenia has been shown to be a considerable therapeutic advance.[4] This, coupled with advances in community care, has had a very beneficial effect on the management and prevention of relapse of rehabilitated schizophrenics living outside the hospital.

The drug is also useful in initiating the treatment of some acutely disturbed patients when they refuse regular medication. On a number of occasions patients who refused all forms of treatment were persuaded to receive a test dose of 12·5 mg. of fluphenazine decanoate and subsequently were willing to continue with a full dose of 25 mg. five days later because of the improvement in their mental state due to the initial dose. Two cases are described because they are illustrative, although in no way exceptional.

A 72-year-old paranoid schizophrenic woman had been in hospital for nine years. Over six months she showed a steady deterioration in her contact with reality, in her co-operation with other people, and in her habits. She was spending all day in a side room with the curtains drawn holding loud conversations with her voices. She refused to attend meals, co-operate in ward activities, or keep her room or her person clean and tidy. She was abusive towards the nursing staff claiming they were stealing her property. She was prescribed chlorpromazine, which she refused to take. She was then prescribed fluphenazine and eventually persuaded to receive this after having seen its beneficial effect on another patient whom she knew well. Within two days she claimed to feel better. She started taking more interest in other people and co-operated better. She gradually stopped sitting and talking in her room. She accepted further injections. Within two weeks she was working at occupational therapy mixing well on the ward, and even taking an interest in the health of the ward staff.

A ward sister, aged 37, was transferred from another hospital in a manic episode of manic-depressive psychosis. She showed extreme irritability, motor restlessness, pressure of talk, and flight of ideas with lack of insight—conforming closely to Jung's "manic ill humour"[5] She refused chlorpromazine denying that she was ill. However, when it was explained that treatment was obligatory, she permitted an injection of fluphenazine to be given. Her extreme irritability responded within a week, and there was a decrease in restlessness and speed of thought. She was willing to accept her second and subsequent injections. It was possible to transfer her to haloperidol orally, on which she was maintained. It was thought inadvisable to discharge a patient with her diagnosis on fluphenazine because of the theoretical possibility of depression[6] and the difficulty of reversing depression with a long acting drug.

It is suggested that disturbed patients who refuse treatment may sometimes successfully start treatment with fluphenazine decanoate, a long acting phenothiazine drug. In several instances improvement was sufficient after initiating treatment for second and subsequent injections to be accepted by the patients without demur.—I am, etc.,

A. C. P. SIMS.

All Saints Hospital,
Birmingham 18.

REFERENCES

1 Dillon, J. B., and Bates, T. J. N., *British Medical Journal*, 1966, 2, 1328.
2 Millar, J., and Daniel, G. R., *British Journal of Psychiatry* 1967, 113, 1431.
3 Silverman, M, and Lopes, W. P., *British Medical Journal*, 1968, 1, 707.
4 Neal, C. D. and Imlah, N. W., *British Journal of Social Psychiatry*, 1968, 2, 178.
5 Jung, C. G., *The Collected Works of C. G. Jung*, Vol. I, London: Routledge and Kegan Paul, 1957.
6 de Alarcon, R., and Carney, M. W. P., *British Medical Journal*, 1969, 3, 564.

## Traveller's Diarrhoea

SIR,—Having recently returned from Mexico, where I was medical officer to the 1,500 or so England supporters, I would like to present the following observations gathered from an admittedly small but probably significant study appertaining to the present controversial use of prophylactic therapy for "traveller's diarrhoea."

I was consulted by 108 people suffering from diarrhoea with or without vomiting/abdominal pain and, of this number, 65% were already taking Entero-Vioform. Most had taken it prophylactically since their holiday started and had increased the dose as recommended when symptoms started.

Only four patients had generalized upset manifested by raised pulse and pyrexia, etc., and they were all taking Entero-Vioform as above.

Ninety-five per cent. of all patients were symptom free within 72 hours of dietary restraint and kaolin compound for the more severe cases. The 40 with toxic symptoms responded well to Streptotriad (sulphadiazine, sulphadimidine, sulphathiazole, and streptomycin) in addition. The remaining 5% had intermittent diarrhoea for a further 7-10 days but were not seriously incommoded by it.

The conclusions from this are easily drawn I think.—I am, etc.,

R. CRUTHERS.

Croydon,
Surrey.

## Body Contour for Radiotherapy

SIR,—I was interested to read Dr. D. E. Meredith Brown's letter on the determination of body contour for radiotherapy (8 August, p. 345). This system has been in use for many years, of course, but it is welcome news that a commercial instrument is available. It is to be hoped that the use of flexible metal strips will soon be relegated to history.

One point, however, is worthy of consideration. If a set of parallel needles is used, skin surfaces which are perpendicular to the direction of the needles are recorded accurately, but those lying almost parallel to the needles are recorded very inaccurately. This difficulty can be overcome either by using two sets of needles positioned on a right angled frame, or by using a device with needles arranged radially around the arc of a circle.—I am, etc.,

L. ARTHUR FIRTH.

Leamington Spa,
Warwicks.

## Propranolol and Serum Calcium in Thyrotoxicosis

SIR,—We were interested to read the paper by Drs. R. G. Twycross and V. Marks (20 June, p. 701) on the control of symptomatic hypercalcaemia in hyperthyroid patients by means of conventional antithyroid therapy. We would like to record our unusual experience of the effect of propranolol in two hyperthyroid patients.

An Indian male, aged 41 years, was first admitted to hospital on 5 January with a history of loss of weight (33 lb., 15 kg.) over two months, weakness, and marked sweating. Clinically he was found to have diffuse thyroid enlargement with a systolic bruit, exophthalmos, lid lag, fine tremor of the hands, pulse rate 140/min., sweaty palms, and a proximal myopathy. His protein bound iodine (P.B.I.) was 13·3 μg./100 ml., 24-hour $^{131}$I uptake 82·2% (normal 15-50%), and latex particulate triiodothyronine $^{131}$I 47·5% (normal 18-28%). He was discharged on propranolol 20 mg. t.d.s. and carbimazole 10 mg. t.d.s.

We saw him for the first time 6 weeks later with new complaints of anorexia, constipation, polyuria, and polydipsia, and he stated that he had stopped his antithyroid drug therapy. Hypercalcaemia was suspected and his serum calcium

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