Vomiting with Clonidine Withdrawal

SIR,—We would like to report a case of persistent vomiting in a patient after rapid withdrawal of clonidine (Catapres). The dangers of paroxysmal hypertension associated with raised catecholamine levels following rapid withdrawal of clonidine are well documented.¹ We have found no previous report of persistent vomiting occurring in this situation.

The patient, a 48-year-old man with chronic glomerulonephritis, developed hypertension in 1973 and was initially treated with methyldopa and then bethanidine. These were discontinued because of side effects and poor control respectively. Clonidine was introduced in October 1973 with good effect at a dose of 0.4 mg six-hourly with propranolol 400 mg daily in divided doses. The patient was referred for consideration of change of treatment in July 1974 because of intolerable nasal congestion associated with nasal polyposis. Finally, in January 1975, this was instituted. On 26 January clonidine was stopped abruptly, the patient continuing on propranolol. Arrangements were made to monitor his blood pressure regularly during the withdrawal period. The next day he felt light-headed and dizzy, and on 28 January he became anorexic. At midnight 28/29 January he started to vomit and had continuous retching until his admission to hospital the next morning. On admission he was dehydrated but showed no clinical evidence of massive catecholamine release. His blood pressure was 140/90 mm Hg. An intravenous infusion was established and he was given parenteral metoclopramide without relief. Finally, it was decided to give him parenteral clonidine. After 0.05 mg intravenously his vomiting stopped dramatically and his nausea disappeared. Clonidine was then reintroduced orally and has subsequently been withdrawn slowly with no recurrence of his symptoms. Catecholamine studies performed during the acute phase were normal.

We assume that the vomiting was a central effect due to rapid withdrawal of clonidine.—We are, etc.,

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¹ Hunyor, S. H., et al., *British Medical Journal*, 1973, 2, 209.

Side Effects of Practolol

SIR,—Your leading article (14 June, p. 577) on the side effects of practolol and other β -blockers states that the eye, skin, and other changes are the result of an immune reaction to these drugs. Though certain manifestations, such as antibody formation and the presence of L.E. cells would seem to support an immune mechanism, there is another possible explanation.

Benner et al.¹ have shown that β -adrenergic blockade increases antibody production in response to antigen challenge and that adrenaline suppresses the normal response to antigenic stimulation. Furthermore, β -blockers interfere with the action of anti-inflammatory agents² and propranolol prevents the response of lymphocytes to phytohaemagglutinin in vitro.³ Finally, adrenaline activates epidermal adenylyl cyclase activity and reduces epidermal cell division.⁴ β -blockers antagonize this effect, suppressing cyclic AMP formation and encouraging cell division, and probably predispose to the development of psoriasiform changes in the skin.

This is an alternative and more rational

explanation for the various cellular and humoral changes described as a result of practolol therapy. The immune mechanism theory sounds plausible but our explanation is more logical, postulating that the side effects are the direct and specific result of pharmacologically induced changes of β -blocking agents.—We are, etc.,

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- 1 Benner, M. M., et al., *Journal of Allergy*, 1968, 41, 110.
- 2 Riesterer, L., and Jaques, R., *Helvetica Physiologica et Pharmacologica Acta*, 1968, 26, 287.
- 3 Smith, J. W., et al., *Journal of Clinical Investigation*, 1971, 50, 432.
- 4 Yoshikawa, K., et al., *British Journal of Dermatology*, 1975, 93, 29.

Diagnosis of Gastric Cancer

SIR,—Dr. A. W. Segal and others (21 June, p. 669) draw conclusions about diagnostic methods in gastric cancer from a study of 32 such cases. In particular, they report an accuracy for endoscopic biopsy of 70% and for endoscopic brush cytology of only 30%. It is indeed surprising that they do not refer to previous and larger "Western" experience,^{1,2} and astonishing not to find a single mention of the huge and relevant Japanese studies, many of which are published or summarized in English language journals. For instance, Kasugai and Kobayashi³ reported an accuracy for endoscopic histology of 92.8% in a series of 751 gastric cancers and a cytology accuracy of 96% in 512 cases.

In a paper on the diagnosis of gastric cancer it is also depressing not to find any reference to the diagnosis of *early* cancer, which must be the important aim. The five-year survival after surgery for gastric cancer confined to the mucosa exceeds 90%.⁴ Early gastric cancer is not a condition peculiar to the Japanese. All cancers must start small. When sought by expert endoscopy and histology they are to be found among Western patients,^{5,6} even in London. The main problem concerns selection of patients for investigation, since early cancer may provoke few symptoms.—We are, etc.,

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- 1 Roca, M., Whitehead, R., and Boddington, M. M., *Topics in Gastroenterology*, vol. 2, ed. S. C. Truelove, and J. Trowell. Oxford, Blackwell Scientific Publications, 1975.
- 2 Nagy, G., *Medical Journal of Australia*, 1972, 1, 403.
- 3 Kasugai, T., and Kobayashi, S., *American Journal of Gastroenterology*, 1974, 62, 199.
- 4 Kasugai, T., *Gastroenterology*, 1970, 58, 429.
- 5 Kobayashi, S., et al., *Journal of American Medical Association*, 1970, 212, 2086.
- 6 Elster, K., et al., *Endoscopy*, 1975, 7, 5.

Sexual Disorders in the Male

SIR,—I have been reading Professor R. W. Taylor's admirably clear articles (28 June, p. 739 and 5 July, p. 32) on sexual disorders, and he, of course, remarks on the way a clinician may get a special selection of cases. I think it is an important point that sexual disorder, though superficially a specific field, is in fact interwoven with various cultural and individual attitudes, including inhibitions.

As a psychiatrist I see sexual cases in the N.H.S. from roughly the same area as Professor Taylor, and I seem to have more young men with what might be labelled primary impotence, mainly precipitated by real or imagined increased expectations of their male group or their girls. These patients do relatively well with simple psychiatric, one might almost say common-sense, treatment in that the external pressure shows up an immaturity which is only relative as opposed to other young impotent men who show a deeper immaturity or block. On the other hand, my general experience of premature ejaculation is less favourable, and I suspect I tend to get more patients with passive and obsessional trends—that is, less reactive than the kind of case Professor Taylor chiefly describes. In some of these cases, in common with other psychiatrists, I have found clomipramine in small doses useful, and I wonder if it has the edge over reserpine as besides slowing ejaculation it can alter mood in some obsessional or mildly depressive cases. Perhaps one might also speculate here how much, besides due to shame, patients present slightly different pictures as they divine the specialist's interests.

Obviously the main criterion of any treatment must be that it works, and I am not urging that all cases should be seen by psychiatrists—all the more as certain specialties must have favourable access to certain situations. Nevertheless, I suspect the situation has been slightly falsified by the tendency to divide cases into "neurotic" and not neurotic, which of course may please one sort of patient, whereas the actual variation in many of these patients lies in the quantity rather than the different quality of their tie-ups. There could be an anti-prophylactic effect in making the treatment into a manoeuvre, leaving out the patient's basic outlook, which may still contain unresolved ambivalence, or over-compensating ideas about virility, etc. Noticeably Masters and Johnson, whom one could hardly regard as going into the "neurotic" side, nevertheless lay great emphasis on getting the basic emotional relation right, beginning from a level which is not functionally sexual. Here, though, a specially favourable and concentrated procedure is possible.

While there must always be exceptions, and it must often be a question how much any patient can take, I would urge that much is to be gained by examining the quasipurposiveness of apparently unwanted sexual reactions—that is, the amount of dislike, fear, boredom, or unacceptable fantasy, etc. Besides giving the patient a firmer base, if these things can be resolved it encourages a general freer acceptance of emotional life as well as physical phenomena, which now is much in fashion. (I am not discussing morality.) However, this kind of purposive interpretation needs in turn to be checked against the more frankly psychosomatic process—that is, any given patient who is depressed, anxious, preoccupied may be impotent or premature—and once this process has started a secondary panic just about that symptom can persist. The relation between these two different kinds of reaction needs proper elucidation, most of which seems to me to come within the psychiatric field.—I am, etc.,

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