Correspondence

Wales 44% of the men and 56% of the women who committed suicide used coal gas. McCulloch, Philip, and Carstairs (1967) reported that of the 216 suicides in Edinburgh in the years 1963–5 40% were due to coal gas, the proportion being the same for both sexes. Your opening sentence should thus have referred to common methods in completed suicides. The last paragraph of your leading article indicates that the neurological prognosis of patients who have inhaled carbon monoxide is generally good, and with this we would agree; but you close with the sentence: “It is a paradox that many patients might not wish it so.” You have failed to appreciate that the vast majority of poisoned patients do not wish to kill themselves, and the motive is unknown for many who die. Kessel1 proposed the term “self-poisoning,” as being more appropriate than “attempted suicide,” as he considers it a term misleading but positively wrong. If these acts have a purpose it is nearly always to alter the social situation, rather than self-destruction.—We are, etc.,

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REFERENCES


Fluphenazine Enanthate in the Maintenance Treatment of Schizophrenia

Sir,—We read with interest the letter by Dr. N. S. Capstick (20 January, p. 181) and review briefly our own experience with fluphenazine enanthate in a 107-bedded unit based on a general hospital. Our experience with this drug is similar to that of Dr. Capstick, but, because of the reluctance on the part of some psychiatrists to use this preparation we feel the need to enlarge on one or two aspects of treatment.

To date we have treated a total of 79 patients, of whom 70 are still receiving maintenance therapy. The failures showed, 7, inadequate response; 1, absconded (therefore excluded); 1, disoriented (abnormal fear of hypodermic needles).

Of the 70 patients 66 are now discharged from in-patient care and are attending the hospital for injection. Four are being stabilized as inpatients.

The following Table may be of interest:

<table>
<thead>
<tr>
<th>Period of Treatment (Months)</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>6-12</td>
<td>18</td>
</tr>
<tr>
<td>12-18+</td>
<td>26</td>
</tr>
</tbody>
</table>

These figures should help to dispel doubts regarding the efficiency of the drug in maintaining patients in gainful occupation in society, thus relieving pressure on the bed state. The readmission rate and the need for further E.C.T. have also greatly diminished. A more extended report on our findings will be published at the end of the year.

It is our practice to start medication as an inpatient, giving fluphenazine orally, followed some two weeks later by 0.25 ml. intramuscularly as a test dose, then by 0.5 ml. about two weeks later. The doses are then adjusted to the individual response, depending upon what the patient can tolerate with minimal side-effects. If there are any side-effects we have a chance to observe them in the initial stages and have been able to control them with orphenadrine or procyclidine. In this group of chronically schizophrenic patients we have found fluphenazine enanthate highly effective, and we feel that psychiatrists need have few qualms concerning toxicity, side-effects, or patient control with a long-acting preparation such as fluphenazine enanthate.—We are, etc.,

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Sir,—The contributions from Dr. N. S. Capstick (20 January, p. 181), Dr. R. Hick and Dr. I. M. K. Ovrenstone,2 and Dr. C. M. Parks et al.,3 bring forward for consideration whether or not the time is opportune to recognize that the phenothiazines exert at least two significantly different effects on the central nervous system. These two separable effects comprise a general sedative effect at subcortical level, and a more specifically directed antipsychotic effect which, if exerted over a sufficient length of time, conceivably may be associated with a destructive lesion, possibly in the strio-nigral system.

In a manner of speaking it is coincidental that we have come to think of these drugs as divisible into a "broad spectrum" group (of which chlorpromazine is a good exemplar) and a "narrow spectrum" group. I say "coincidental" because probably those phenothiazines which are utilized by us primarily for their general sedative effect do not produce a specific antipsychotic effect unless we use them in sufficiently high dosage to procure an antipsychotic effect; and vice versa with the narrow-spectrum antipsychotic drugs. If these hypotheses correspond to fact then it may be that in many patients a rational therapy would be to combine the use of small doses of a broad-spectrum (sedative) drug such as chlorpromazine with a narrow-spectrum antipsychotic drug.

What is now emerging from your columns is that there are increasing numbers of patients, especially in the older age groups (who are predisposed to degenerative lesions by virtue of their impaired cerebral circulation) who develop these choreiform movements, and less frequently hallucinations and atherosis. I think it possible that with some of these patients (especially the older group) these effects are not reversible and are not easily covered up by such drugs as orphenadrine, because, I believe, there has in fact accrued a destructive lesion.

REFERENCES


Identification of Tablets

Sir,—I understand that there is, at present, a working party appointed by the B.M.A., the British Pharmaceutical Society, and the Ministry of Health to consider this matter. I wish to make it clear that the case for identification of tablets is overwhelming and this system should indeed have been introduced many years ago. Identification of tablets was introduced by an individual firm (under the trade name of "Co-tabs"), but instead of receiving support this firm’s individual effort was censured.