Problems in Amphetamine Usage

Sir,—I was somewhat surprised to read the views of Dr. H. E. Lewis regarding the problems in amphetamine usage (24 April, p. 243). He appears to have overlooked several fundamental points on the misuse of amphetamine.

Firstly, patients very often become dependent on amphetamine through the prescribing of this product for the treatment of obesity; this includes the products Durophet and Durophet M. These two products, together with plain tablets of amphetamine and diethylpropion, have for some time been sold on the black-market under a wide variety of slang names, such as "black bomber," "bennies," "black and tans," "French blues," and "purple hearts," etc. All these drugs are included in the Drugs (Prevention of Misuse) Act, 1964, because they are recognized as drugs which can lead to tolerance, dependence, and abuse. It was stated in the British Medical Journal that the drugs dexamphetamine, phentimetrazine, diethylpropion, and amphetamine, in view of their addictive properties, should be prescribed only in exceptional circumstances.

The letter from the Chief Medical Officer of the Ministry of Health (23 March, p. 754) does not suggest that any evidence has been brought to light over the last seven years to modify this opinion. It seems peculiar, at least, to suggest that altering the formulation of such a potentially dangerous drug as amphetamine can make any difference to its harmful effects. Does such a change alter the pharmacology of amphetamine? Dr. Lewis may be correct when he says that there are pharmacological differences between various members of the amphetamine family but only when compared under controlled circumstances. However, he has failed to point out that compounds substituted in the benzene ring, such as chlorphentermine and fenfluramine, appear to be safer in practice than the other products.

A recent paper (30 March, p. 796) suggested that fenfluramine may prove not to have any dependence-inducing properties at all because of its lack of harmful effects on sleep, whereas amphetamine, phentimetrazine, and diethylpropion cause such harmful effects that they cannot be used without the literature issued by the pharmaceutical industry. The majority of those who request deletion from the list eventually ask for full or partial reinstate-ment. We receive many more requests for deletion than from our mailing lists.

The final point which arises from Dr. Samuel's letter is his apparent surprise that official publications are distributed by this company. The explanation is, however, simple. It is recognized by these official bodies, as well as by pharmaceutical manufacturers and periodical publishers, that the lists maintained by the Medical Mailing Company are the most accurate available for the distribution of information to the medical profession. In 1967 a total of 87,560 items were examined and 22,994 corrections made to our lists to ensure an accuracy of 99.9%.

Gavin R. Thompson, Joint Managing Director, The Medical Mailing Company Ltd.
London W.1.

Metabolic Acidosis in Burns

Sir,—In his article on metabolic acidosis in burns (30 March, p. 809) Dr. M. J. T. Peaston has satisfactorily documented this fact. His own comments include reference to shock as well as renal failure being possible causes of this condition. It would be interesting and helpful to know how many of his patients were in a state of clinical shock during the period of observation. Similarly, although overall fluid and electrolyte balance for the total period of study is specified, this gives no indication of the adequacy of renal function during the first 24 to 48 hours after the burn, and blood urea and creatinine levels would be helpful to try to assess the importance of the two postulated causes for the observed acidosis. I am, etc.,

Adolf Singer.
Mount Sinai School of Medicine,
New York, N.Y., U.S.A.

Air Bubbles in Plastic Syringes

Sir,—Further to the inquiry by Dr. C. C. M. Watson (27 April, p. 246), I would like to offer the following simple remedy. The syringe is held vertically, needle uppermost, as a feather is drawn in. If the syringe is then flicked gently all the bubbles coalesce and can be expelled together. Unfortunately the above technique does introduce the theoretical risk of infection, but surely no more than the prior injection of air into multi-dose containers before aspiration, which was a widely used practice.

It should also be pointed out that the new syringe should be carefully tested before use, as aspiration of blood during venepuncture is impossible if the plunger is stuck, which occurs in a small but significant proportion of cases.—I am, etc.,

Liverpool 12.

R. E. D. Hamm.

Anesthesia for Insertion of Arteriovenous Cannula

Sir,—Two alternatives have been suggested to overcome the problem of anesthesia for insertion of Teflon Arteriovenous cannula.1 One is the use of brachial plexus block, and the other general anesthesia. Brachial plexus block has been

References

abandoned after a short trial owing to the time-consuming nature of the shunt procedure, as well as the emotional problems associated with patients under these conditions. General anaesthesia was then offered as the only alternative. As is well known, there are many problems which confront the anaesthetist involved in these cases, not least of which must be mentioned the possibilities of anaemia, metabolic acidosis, and electrolyte imbalance, especially involving serum potassium levels. To complicate the issue further these patients tend to vomit, and have an unstable response to variations in circulating fluid volume.

The Hospital shunts are inserted using local analgesia at the site of insertion, with the occasional demand for general anaesthesia in certain patients. In view of the problems just mentioned, for the last six months we have used dehydrobenzperidine (Droperidol) combined with local infiltration of lignocaine at the shunt site as a preferable alternative to general anaesthesia. The advantages of this scheme are that it seems very apprehensive intraoperative patients have minimal effects on blood pressure; patients are co-operative; and their reflexes remain fully active. The anti-emetic effect of this drug is a considerable advantage, and its length of time of action (8-12 hours) ensures adequate operating conditions for what is often a lengthy procedure.

Early discharge from hospital is possible. Initially these patients are given 5-10 mg. dehydrobenzperidene orally one to two hours before the procedure, and a further dose of 5 mg. is repeated intravenously in theatre if required. Local infiltration of 2% lignocaine without adrenaline at the shunt site is then performed. This procedure has given such satisfactory results that it has now been used routinely for the insertion of all shunts in this hospital.—I am, etc.,

Doreen R. G. BROWNE
Royal Free Hospital, London N.W.3

Reference
1 Royal Society of Medicine, Meeting 5 April 1968, unpublished.

Monoamine Oxidase Inhibitors

Sir,—Your article on monoamine oxidase inhibitors (Today's Drugs, 6 April, p. 35) particularly stresses the interaction with other drugs and foods. However, it appears that patients are still not sufficiently warned about these dangers, nor of the importance of telling other doctors that they are taking monoamine oxidase inhibitor drugs.

An apparently intelligent woman was recently admitted to this unit for a varicose-vein operation. She told the house-surgeon that she was on pills for her irregular periods, which he initially assumed to be a hormone preparation, but, on further questioning the evening before operation, it transpired that she were called Mandil (phenelzine). She had not told the ward sister that she should not be given cheese or Marmite for her work. The surgeon, who had seen her general practitioner had told her about this. She denied, however, being warned that there was a danger to having an anaesthetic or other drugs, and she had been given phenelzine while on the waiting-list for operation.

We have had another similar case in the last few months. Surely the practice of giving the patient precise instructions and a card to carry should by now be universal, as with anticoagulants and steroids?—I am, etc.,

ALAN G. JOHNSON
West London Hospital, London W.6

Reference

Heart Transplant Publicity

Sir,—Everybody will congratulate the team who carried out the so far successful heart transplantation at the National Heart Hospital. But why is such blatant publicity considered necessary? It cannot be to advertise the well-known surgeons; that would be quite unethical. It cannot be to advertise the hospital, which is well known. It cannot be to obtain donors. It may be necessary for the South Africa to boost its surgical skill, but surely British surgery does not require a boost. Every week hundreds of life-saving operations are performed in this country without mention in the press. I much regret this, to me undignified, publicity.—I am, etc.,

M. F. CUTHBERT
Royal Free Hospital, London N.W.3

Reference

Ethchlorvynol Withdrawal Symptoms

Sir,—This report illustrates symptoms which followed the abrupt withdrawal of ethchlorvynol. This drug, which was introduced in North America in 1955, is a halogenated acetylcarbolic which anti-convulsant properties were originally discussed by Pan et al.4

A man aged 67 was admitted to the Royal Infirmary, Sheffield, on 3 November 1967 for