Fluphenazine Injections: Adverse Effects and Treatment Failures

Sir,—I wish to describe the adverse effects and treatment failures encountered during attempts to medicate 70 schizophrenic patients with injections of fluphenazine enanthate or decanoate during the past five years. After initial stabilization, usually in hospital, injections were given three weekly in 38 patients and twice weekly in 24 others over an eight-week period. In eight cases, all except five patients have received 25 mg of fluphenazine at each injection; four received 12.5 mg, and one 37.5 mg. In addition, oral tranquilizers were prescribed for the patients and on the occasions when were given routine anti-Parkinson drugs, usually orphenadrine.

The present survey has not revealed any straightforward relation between treatment and adverse effects. In five of the six cases treatment had to be stopped because of depression. In four cases this was sustained and it followed each injection in one; three improved spontaneously and two recovered during courses of electrolysis. Four of those who were receiving decanoate; seven who patients appeared to have responded well to treatment, had suffered mild depressive episodes; from which they had recovered. The problems, one to electrolysis, one to a reduction in injection frequency, and one improved spontaneously.

There was no patient suffering from typical extrapyramidal symptoms. We have observed a weekly depression appeared when treatment was interrupted and remitted when fluphenazine was resumed.

Two patients committed suicide. One was a 32-year-old man who was improving; with three weekly injections, but who became depressed after accidentally missing an injection. He improved when treatment was resumed, but again missed an injection and killed himself shortly afterwards.

Estimates of the incidence of extrapyramidal side effects vary considerably. We probably gave routine anti-Parkinson drugs more frequently than was strictly necessary in an effort to ensure that these difficult and often initially uncooperative patients were given no reason for stopping treatment.

In three cases treatment had to be stopped because of the extrapyramidal side effects which did not respond adequately to the usual remedies. Eleven other patients showed moderately severe extrapyramidal side effects which did not lead to cessation of treatment. Only two of them admitted any awareness of these effects.

Treatment had to be stopped in five other cases, for the following reasons: lack of cooperation—two; excessive drooling—two; persistent vomiting of undetermined cause—one. In addition to the 13 patients whose treatment had to be stopped, nine other cases have been classified as therapeutic failures for the following reasons: psychotic relapse—two; inadequate response to treatment—seven.

The remaining 46 patients appear to have done well, with obvious remission of symptoms and much less time in hospital since fluphenazine injections were started. They have now been treated for periods ranging from 18 months to 2 years. As a result of fashionable efforts to keep patients out of hospital at practically any cost time spent in hospital no longer mirrors the duration and severity of mental illness as accurately as it used to. Nevertheless, it is interesting to note that for this group of 46 patients the total time interval between the onset of illness and the start of fluphenazine injections amounts to 434 patient-years, 16% of these patient-years have elapsed since then, 3.3% of which have been spent in hospital.

Obviously, the results of a retrospective study must be interpreted very cautiously. However, it is worth noting that nine of the 11 patients who suffered adverse effects leading to the interruption of treatment were receiving fluphenazine decanoate. The other therapeutic failures were divided almost equally between the fluphenazine enanthate, as were the apparent successes. Most of the latter are paranoid schizophrenics with fairly well preserved personalities, who have proved to be unrelenting in goals, like a small subsection of a class of patients who already carry a fairly good prognosis. The seven classified as “inadequate response to treatment” were almost certainly fairly reliable pill-takers who had shown an inadequate response to oral medication; four of them showed quite severe personality deterioration.

These findings suggest that although fluphenazine injections are a valuable addition to a current method of treatment, their benefit will be mainly felt by those patients with moderately severe illness who alone appear to have benefited from advances in treatment during the past 30 years. The hard core of more severely ill patients is the subject of the next paper. It is likely to remain unaffected, and the problems associated with long-term medication will grow even greater.

I would like to thank Dr. M. C. Moss who allowed me to include some of his patients in this survey, and the nursing staff of the Ashfield Clinic, whose co-operation made it possible.

—J. A. E., etc.,

Ashfield Clinic, Kings Mill Hospital, Sutton in Ashfield, Notts

Title for Anaesthetists

Sir,—The proposed formation of a College of Anaesthetists leads me to suggest that the College use one of the terms of the specialty, avoiding the American word “anaesthesiology,” which has never rung true to most British ears even though it has been adopted by the World Federation. This original thought came from the name “Clinical Physiology” has been put forward in the past. I am not agreeing that this name is an ideal description of the work of a medical department of anaesthesia, and perhaps something like “Physician in charge of Clinical Physiology and Resuscitation,” even though cumbersome, would be a more apt title than “Anaesthetist.”

History tells of the prolonged argument of last century over what name should be given to the discoveries of Crawford Long, Morton, Wells, and Simpson. This argument was won by the British Cabinet, who coined the word “anaesthesia.” I appeal for a British genius to find one all-embracing word to add to our language.—I am, etc.,

Michael A. E. Ramsay

Anesthetic Department, The London Hospital, London E 1


Coalworkers’ Pneumoconiosis

Sir,—We agree with Professor I. T. T. Higgins (17 June, p. 713), “that neither ventilatory lung function nor emphysema is related to x-ray category of simple pneumoconiosis in cokemakers.” We have not found, however, that there is little correlation between pulmonary function tests and radiological categories of x-ray in simple pneumoconiosis and we repeated in our article (18 March, p. 713) that “these reductions [in pulmonary function] are not related to category of simple pneumoconiosis.” We agree with Rossiter that numerical radiological category is well related to the dust content of the lungs after 1957 and there is no correlation between dust content and pulmonary function. But the postmortem dust content is not necessarily a measure of the cumulative exposure of dust during life, nor of the pathological damage to the lungs caused by dust.

We agree with Cochrane and Higgins that there is no sound evidence to suggest an association of decreasing ventilatory function with increasing category of simple pneumoconiosis. As our study was based on miners who subsequently died in a defined area and theirs on random samples of living miners drawn from defined populations we were not surprised at this essential agreement. They continued: “there seems to be evidence for some decrease in ventilatory function in elderly miners . . . unrelated to dust content as seen in the radiograph.” We find a similar decrease at all ages, which we suggest is due to emphysema which they could not measure in living subjects.

We followed Dr. C. M. Fletcher’s advice (8 July, p. 116) and expressed mean emphysema counts in relation to median (not mean) category of films read independently by two or more observers (highly experienced) on two or more occasions. We found, and reported in our article, a poor correlation. In...