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 decanate during the past five years. After initial stabilization, usually in hospital, injections were given three weekly in 38 cases, fortnightly in 24, and monthly and weekly 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 patients and injections were given routine anti-Parkinson drugs, usually orphenadrine.

The present survey has not revealed any straightforward relation between treatment and side effects. In five cases treatment had to be stopped because of depression. In four of these cases was sustained and it followed each injection in one; three improved spontaneously and two recovered during courses of electroplexy. Four of those receiving decanate; seven patients who appeared to have responded well to treatment, were given routine anti-Parkinson drugs, usually orphenadrine.

There was one patient suffering from a typical paranoid schizophrenia in whom a weekly depression appeared when fluphenazine treatment was interrupted and remitted when fluphenazine was resumed.

Two patients committed suicide. One was a 36-year-old man who was impotent before treatment. He was given routine anti-Parkinson drugs, usually orphenadrine.

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 as a result of severe 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.

Tetany 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 from 18 months to 70 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. The mean patient-years of these patient-years have elapsed since then, 3.3% of which have been spent in hospital.

Obiously, 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 decanate. The other therapeutic failures were divided almost equally between chlorpromazine, as were the apparent successes. Most of the latter are paranoid schizophrenics with fairly well preserved personalities, who have proved to be unreliable pill takers. It is clear, therefore, that, as 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 adequate response to oral medication; four of them showed quite severe personality deterioration.

These findings suggest that although fluphenazine injections are a valuable addition to treatment methods, 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 severely ill patients is likely to remain unaffected, and the problems associated with long-term medication will grow ever 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 Asfield Clinic, whose co-operation made it possible.

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Title for Anaesthetists

Sir,—The proposed formation of a College of Anaesthetists leads me to suggest that the term "anaesthetist" is one of the specialties of the specialty, avoiding the American word "anesthesiology," which has never rung true to British ears even though it has been adopted by the World Federation. This original thought was that 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 American Wendell Holmes, who coined the word "anesthesia." I appeal for a British genius to find one all-embracing word to add to our language.—I am, etc.,

Vernon Coleman
Inkpen, Berks

Anaesthesia by Acupuncture

Sir,—I was intrigued to read the report of Dr. S. G. Hamilton and others (5 August, p. 352) of operations performed under acupuncture anesthesia. In particular the description of a pneumoconiosis performed with one needle inserted in the deltoid muscle. Does this mean that the basic problems of an open chest and collapsed lung have been overcome by acupuncture? I would be grateful to hear more details of this procedure.—I am, etc.,

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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 Cilgerran." We have not made a measurement of any kind. Furthermore, 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 death. We do not claim that there is a correlation between the 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 subjects, we are 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 deposition 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

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our first paper we reported a high prevalence of emphysema in the miners compared with a matched group of controls. Some of our subjects had no history of smoking and this prevalence was not correlated with age nor with category of radiograph. We illustrated this point with photographs of four whole lung sections. We found and reported a high correlation between emphysema and impaired pulmonary function. This impairment was obstructive in type.

We do not equate identically coalworkers' pneumoconiosis with persistent nodular radiological opacities in the lung fields provoked by the inhalation of dust. The disease is a complex biological process consisting of the provocative agent and the host response. The conclusion to our study is that nodulation and fibrosis, a further and probably subsequent reaction is lung destruction (emphysema). The nodular changes may correlate with radiology; the true changes are not but do correlate with impaired pulmonary function.

The importance of emphysema in the pathology of the disease has been described previously. Gough and colleagues had reported a high prevalence of lung disease among coal miners related to the terminal and respiratory bronchioles and concluded that the lungs could withstand this without harm for some years. In miners who had been exposed to dust for 20 years he demonstrated emphysema with dilatation of the proximal bronchioles. After 40 years exposure the majority of his miners showed focal dust emphysema but no change in the distribution of coal dust specifically related to the terminal and respiratory bronchioles and concluded that the lungs could withstand this without harm for some years.

Furthermore, we related ventilatory capacity and lung volumes to the type of pneumoconiosis—fibrotic, or nodular (p, q, or r)—in the chest radiograph. In our group of working miners from Pennsylvania and West Virginia there were no differences in pulmonary function except in the diffusing capacity of those with the p and q type of opacities. We also found a virtually identical mean pressure-volume curve in 10 working miners with predominantly p opacities and in 15 with predominantly q opacities, whereas a normal curve was found in 10 control subjects. Nevertheless, a reduction in maximal expiratory flow rates was present in both groups, but it did not differ in relation to the type of radiographic opacity. Therefore, neither the diffusing capacity, lung volumes, pressure volume curves, nor ventilatory capacity suggest the presence of significantly more emphysema in miners with p as opposed to miners with q opacities.

We feel that Dr. Lyons and his colleagues dismiss a little too hastily the role of chronic bronchitis—perhaps bronchiolitis would be a better term—in producing respiratory impairment. We have shown that the ventilatory capacity of bronchi and alveoli and is probably not the same fraction that is responsible for the radiographic changes in coalworkers' pneumoconiosis. Furthermore, we have shown a minimal reduction in ventilatory capacity in face workers as compared to surface workers. Despite our feeling that the bronchitis of coal miners is probably partly dust induced, the subject of the current debate is that of cigarette smoking. When considering the problem of bronchitis and ventilatory impairment in coal miners Dr. Lyons and his colleagues seem to place undue reliance on the Reid index and standard tests of ventilatory capacity. We have shown that non-smoking miners with radiographic evidence of pneumoconiosis but with a normal ventilatory capacity often demonstrate frequency dependence of compliance and an increased residual volume. The presence of these abnormalities suggests an increased resistance to flow in the distal airways which could be due to bronchiolitis of occupational origin.

Finally, there is often a lack of correlation between the postmortem finding of emphysema and the presence of symptoms and impairment in life. While not denying the postmortem presence of emphysema in the deceased miners described by Dr. Lyons and his colleagues, we associate it with antemortem pulmonary impairment may well be unjustified. We are, etc.,

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N. LE ROY LAPP

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Consent to Operation

Sr,—Having spent approximately three years in charge of Hargreave Hospital in British Somaliland, where most patients were Mohammedans, I would like to draw your attention to the importance of the present form of consent advocated by the Medical Defence Union, which states that "the nature and purpose of the operation has been explained to the patient, particularly, especially in relation to colostomies or any other form of diversion to the alimentary tract with an abdominal opening. Mohammedans, as many may realise, have very specialized views on the subject of the lower bowel contents, and I am sure that in many cases death would probably be preferable to them rather than consideration of such a surgical procedure. I am aware that this may not refer to the existing "Anglicized" Mohammedan population, but it will to newcomers as the rate of immigration increases.

I am in receipt of a letter from the Medical Defence Union which states that the Mohammedan patient "does not realize what a colostomy involves," and I have been advised by the M.D.U. to write this letter to various journals to the above effect.—I am, etc.,

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New Consultant Contract

Sr,—Dr. D. E. Bolt and Mr. P. F. Jones (12 August, p. 414) say that the work that consultants do for the N.H.S. is often "far in excess of their contractual obligations." It cannot be said too often that as far as whole-time and maximum part-time consultants are concerned this is impossible, since the former have contracted to devote the whole and the latter substantially the whole of their time to the N.H.S.

The belief of Mr. Bolt and Mr. Jones arises from a popular misconception—