Depressive Changes after Fluphenazine Treatment

Sir.—The development of long-acting phenothiazines is an important technical advance in psychopharmacology. As Drs. R. de Alarcon and M. W. P. Carney pointed out in their introduction to their report on depressive mood changes following the use of slow-release intramuscular fluphenazine (6 September, p. 564), it is becoming increasingly popular as the method of choice in maintaining schizophrenics in the community. Severe depressive reactions as a result of the drug would be a setback in this therapeutic progress, but, despite their detailed evaluation, the authors did not convincingly prove that fluphenazine is not a new drug. It has been available, and widely used, in oral form for ten years. If it were as potentially depressant as they suggest it is surprising that this has not been noted before. The long-acting injectable drug is still fluphenazine, and there is no evidence of pharmacological alteration by this technical change in the mode of administration.1

The phenothiazines as a group, considering their very widespread use in psychiatry, have not been reliably associated with genuine depressive mood changes. The a priori reasons for believing that these drugs cause depression are not obvious.2

Unless there is some acceptable explanation why long-acting injectable forms should be different from oral forms, it might be better to consider the fact that mood disturbance is a common feature of schizophrenia and suicide is a not uncommon outcome of this disease. It is widely recognized that suicide is a particular danger during the treatment phase in depressive psychoses, owing to the alleviation of retardation in advance of the depressive thoughts. We do not normally consider that oral tranquillizing therapy or antidepressants are depressant because of the suicidal incidence following their use. The schizophrenic under treatment may well be at risk owing to clinical changes such as returning insight. The risks of not treating the condition are much greater. It is abundantly clear that many schizophrenics do not take oral medication. Long-acting phenothiazines provide the best answer to date for this particular problem, and we hope that an over-ready acceptance of depression as a serious objection to this method of treatment does not inhibit its advance, and it need not differ qualitatively from Drs. Alarcon and Carney's concern, that careful supervision is maintained.—I am, etc.,

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REFERENCES
2 O'Brien, M. D., Communication to Third International Symposium on Cerebral Circulation Research, Salzburg, 1968, in press.

Iatrogenic Dermatitis

Sir,—Your leading article on rosacea-like dermatitis (6 September, p. 545) warns that topical corticosteroids may worsen the condition, but there are occasions when they appear to cause it. I have described (15 March, p. 671) the rebound papulo-pustular reactions which may follow cessation of application of topical fluorinated corticosteroids in patients with rosacea. Since then I have seen similar acute papulo-pustular reactions in other conditions, than rosacea, in particular in acne vulgaris.

A boy of 13, who was seen first on 5 December 1968, had suffered from acne vulgaris of his face and shoulders for a year, and for the preceding four months had applied betamethasone valerate ointment three times daily to his face. When seen first he showed the typical telangiectasia and erythema of the central face due to over-dose of topical betamethasone. Four days after ceasing to apply the ointment his cheeks and chin became erythematous and studded with small papulo-vesicles, an appearance similar to an acute contact sensitivity. It was noticeable that the eruption was symmetrical, and clinically he resembled the acute phase of perioral dermatitis. After three weeks on oral tetracycline 250 mg, twice daily, and the application of hydrocortisone ointment his skin had apparently recovered.

Since the observations on rosacea, particular attention has been paid in our department to inquiry as to the local treatment used by patients with perioral dermatitis prior to their referral to hospital. All the last 10 patients with this condition seen in our department had used fluocinolone or betamethasone valerate for periods of from two months to six years. Several patients were, unknown to their own doctor, using these substances which had been prescribed for dermatoses or acne vulgaris. It has been suggested that the increased fusion rate of 22-5% during the prodomal phase (P > 0.005), but only a small, though significant, increase of 8-3% (P > 0.02) in the headache stage. This small increase is quite compatible with a reactive hyperaemia following vasoconstriction in the prodomal stage, but is hardly sufficient to cause symptoms such as headache. Drs. Skinhsj and Parkinson made no increase in flow during the headache stage compared with their normal values, but this figure should be treated with some caution, since the resting flow in their patient is not known and this, together with the error associated with the method, means that no certain conclusions can be drawn from a single observation in one patient.—I am, etc.,

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REFERENCES

Origin of the Third Heart Sound

Sir,—I would like to amplify one point arising from the correspondence (6 September, p. 597) on the origin of the third heart sound and ventricular filling which might otherwise give rise to some confusion. Cine-ventriculographic studies which have shown that mitral valve action is a vortex-dependent mechanism with dye circulating in the retrovalvular zones in a manner analogous to the fluid motion in the sinus of Valsalva during systole. They also show that the mitral valve closing after atrial contraction. Therefore the non-dimensional terms governing vortex formation and decay (the Reynolds and Strouhal numbers) can be applied to this situation. The existence of the upper limit of Strouhal number, the frequency parameter governing the time-dependent circumstances of vortex generation, and a lower limit of Reynolds number, the viscosity parameter governing the liability of a vortex to occur and persist. The duration of diastole suggests that it is the vortex decay term that is especially critical to valve closure and as a result to valve efficiency. The fastness of the ventricular filling curve after the rapid filling phase (diastasis) and then its sharp rise with atrial contraction strongly suggests that atrial systole should be seen as a means of aiding valve closure by giving the vortex an added impetus in the latter part of diastole.