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ACUTE PSYCHOTIC EPISODES IN PATIENTS TREATED WITH FLUPHENAZINE ENANTHATE

DEAR SIR,

Fluphenazine enanthate (F.E.) is a new type of neuroleptic drug obtained by combining a fatty acid with fluphenazine (a phenothiazine of the piperazine group) prepared in sesame oil. When it is administered intramuscularly or subcutaneously the therapeutic agent (fluphenazine) is gradually released over a period of two weeks, and because of this it can be prescribed in a dosage of 1 ml. every two weeks (Kinross-Wright *et al.* 1963). Clinical data reported by several investigators who have used it to treat schizophrenic patients show that its pharmacological and therapeutic effects are comparable to fluphenazine hydrochloride (Kurland *et al.* 1964) and that it is particularly useful for the treatment of acute schizophrenic reactions (Kline and Simpson, 1964).

My own clinical experience confirms the favourable opinions of it for the treatment of chronic schizophrenic patients, but at the same time casts some doubt on its usefulness in preventing the occurrence of acute psychotic episodes.

The following illustrative cases belong to a group of 25 chronic schizophrenic patients suffering from delusions and/or hallucinations and treated on an ambulatory basis with F.E.:

(1) A 25-year-old Negro male with a history of schizophrenia, paranoid type, of long duration, was started on F.E. on 13 December, 1967. At the time of his first clinical evaluation he was in good contact, well related, friendly, co-operative and normally talkative. However, abstract thinking impairment and delusional ideas were easily elicitable, and he admitted experiencing frequent auditory hallucinations. He received 1 cc. of F.E. weekly for the first three weeks and 1 cc. every two weeks thereafter. At the end of February 1968 he was greatly improved, his symptoms had completely disappeared, and he returned to work. He continued to attend the psychiatric clinic regularly, and on 22 April he received, as scheduled, 1 ml. of F.E. Four days later he was brought back to the clinic by his brother because he had become argumentative, extremely delusional and acutely hallucinating, and was admitted to hospital.

(2) A 35-year-old Puerto Rican seaman with a history of schizophrenic reaction, paranoid type, of at least one year's duration. While at sea, he began to suffer from auditory hallucinations of such intensity and frequency that he was discharged from duty. For about a year he was treated with various phenothiazines, but at the time of his referral to our clinic his auditory hallucinations were still continuous and troublesome. He was started on F.E. on 10 April, 1968, 1 ml. weekly for the first three weeks and 1 ml. every two weeks thereafter. On 6 June he received his sixth dose; at that time the auditory hallucinations had completely disappeared and his mental condition was considered much improved. But a week later he was brought in to the emergency room by a relative because of a sudden recurrence of severe, threatening auditory hallucinations. He was admitted to a psychiatric ward.

(3) A 29-year-old Puerto Rican woman with a history of schizophrenic reaction, paranoid type, characterized by impaired abstract thinking, poor judgment, lack of insight, ideas of reference and auditory hallucinations. At the time of referral she was symptom-free, as she had responded favourably to other phenothiazine therapy, but as she was felt to require maintenance pharmacotherapy, and as she often neglected to take the prescribed oral medications, she was started on F.E. treatment. She received her first dose of 1 ml. on 1 May, 1968, and 1 ml. every two weeks thereafter. One week after receiving her fourth dose she again developed ideas of reference, auditory hallucinations and verbal aggressiveness towards her husband. One ml. of F.E. was given immediately, and this was repeated on 25 June and 2 July, but there was practically no improvement and she was therefore put on to a different drug regimen.

These three clinical cases show that F.E. may not prevent the occurrence of acute psycnotic episodes, and that in such circumstances its therapeutic effect may be of limited value.

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STEREOTACTIC TREATMENT OF PARKINSONISM

DEAR SIR,

The clinical findings and the results of psychological testing of patients submitted to stereotactic treatment of parkinsonism reported by D. Asso *et al.*

(*Journal*, May 1969, p. 541) are consistent with the general body of evidence which indicates that the thalamus of the dominant hemisphere, and its ventrolateral nucleus in particular, take part in the speech functions of the dominant hemisphere (Bell, 1968). In Table I they indicated that eight patients had post-operative dysphasia, and they also reported that the patients submitted to thalamotomy 'showed significantly more deterioration than the controls on speech', but unfortunately they did not indicate whether the lesions in these cases were in the dominant or the non-dominant hemisphere. However, an immediate post-operative change in cognitive function indicating impairment in the auditory-verbal modality resulted from lesions in the dominant hemisphere.

Although the findings are not exceptional, their conclusions are. The authors argue that because the auditory-verbal impairment was transitory it could not have been due to the lesion in the nucleus ventralis lateralis. Surely a transitory disorder is the typical result of any single lesion that affects speech? The transitory nature of the dysphasia after a cortical excision in the dominant parietal lobe has certainly not deterred others from claiming that this area is involved in speech functions.

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SLEEP PATTERNS IN PREGNANCY

Dear Sir,

Karacan *et al.* (*Journal*, August, 1969, p. 929–35) report that in 'late' pregnancy subjects experience a prolonged sleep latency, a greater number of awakenings, a shorter total sleep time and a 'suppression' of stage 4 sleep. These authors offer several elaborate explanations of their findings, including 'a subclinical depression' and 'hormonal changes' late in pregnancy; but they rightly state that 'the mechanism of these sleep disturbances is unknown'.

I too would like to speculate as to cause, but in a more mundane fashion.

Women in their last trimester support an abdominal protuberance of some size, and once in bed are faced with the task of moving their extra mass from side to side. This manoeuvre undoubtedly required some skill and dexterity. I would suspect that any woman embarking on such manoeuvres throughout the night would have a prolonged sleep latency, a greater number of nightly awakenings, less total sleep time and a 'suppression of stage 4 sleep'.

Although without hard data to support my conclusions I feel that anyone who has spent one or more nights sharing the bed of a 'woman with child' will surely find heuristic value in my speculations.

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DERMATOGLYPHICS AND SCHIZOPHRENIA

Dear Sir,

One of the major inquiries of a neurogenetic unit of a psychiatric hospital would concern cytogenetic studies in schizophrenia. Recent publications by Kaplan, Judd and others, however, have reported data suggesting that there are inconsistent differences in karyotype pattern found in cases of schizophrenia. Thus, our original intention to screen cytogenetically the newborn offspring of schizophrenic women in this hospital had to be abandoned.

The observations by Raphael and recently by Sanks on dermatoglyphic aberrations (digital ridge dysplasia) in schizophrenic children suggested other possibilities of screening the newborn children.

This preliminary investigation on 17 pregnant women (diagnosed as different types of schizophrenia) and 14 newborn children who were examined, produced quite interesting findings. Nine mothers showed the typical digital ridge dysplasia, while 6 out of 14 investigated children showed this abnormality. Questions regarding pedigree, racial differences and sex differences of offspring, etc., should be discussed in more extensive investigations.

The findings suggest, however, that one should undertake dermatoglyphic tests on a larger scale, either in the described form with pregnant women or in special schools for emotionally disturbed children and their parents. The eventual value of these investigations lies in the possibility of an earlier diagnosis of a schizophrenic tendency in children, particularly of parents with this disease.

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