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ANTIPARKINSONIAN MEDICATION IN DEPRESSED SCHIZOPHRENICS ON DEPOT NEUROLEPTICS

DEAR SIR,

Recent work has confirmed the need for antiparkinsonian medication in neuroleptic treated schizophrenia (Manos *et al*, 1981) and suggested that 68 per cent of patients given placebo developed extrapyramidal side-effects. In another report Johnson (1981) indicated a tendency for depressive-type symptoms to improve when these patients were given orphenadrine 50 mg twice daily. However, he considered that some of the symptoms may have been neuroleptic drug-induced akinesia rather than depressive in origin.

This report relates to the outcome of a single blind cross-over study comparing sustained release benzhexol (Artane Sustets) with procyclidine hydrochloride in schizophrenia treated with depot neuroleptics. The results from 33 patients are available. They consist of 18 men and 15 women with a mean age of 47 years who were receiving depot neuroleptics for chronic schizophrenia. Nineteen patients had been prescribed fluphenazine decanoate and 14 fluphenthixol decanoate. Before entry into the study the patients were not receiving antiparkinsonian drugs. On recruitment the patients were either prescribed sustained release benzhexol 15 mg as a single morning dose or procyclidine hydrochloride 5 mg 3 times daily. On completion of 7 days' treatment the patients prescribed benzhexol were given procyclidine for 7 days and those commenced on procyclidine were given benzhexol. Extrapyramidal signs and symptoms were recorded on day 0, 7 and 14 on a 4 point scale as being absent, mild, moderate or severe. The data analysis showed that the 2 groups of patients were comparable at entry to the study and that there was no significant difference between benzhexol and procyclidine in the management of rigidity, tremor or akathisia. Both drugs were found to be equally effective.

Of 9 patients in the benzhexol-treated group reporting depressive symptoms initially, 7 were found to be improved after one week as compared with only 4 of 9 patients on procyclidine. This result, though interesting, did not reach statistical significance, but the trend observed here accords with that noted by Johnson in patients treated with orphenadrine. Could it be that there is a case for offering schizophrenic patients on neuroleptics an antiparkinsonian rather than antidepressant drug when they present with depressive type symptoms?

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POSITIVE AND NEGATIVE SCHIZOPHRENIC SYMPTOMS

DEAR SIR,

Crow in his discussion papers (1980, 1981), and Wing (1978), have not been explicit about their use of the concept of positive and negative symptoms. This concept has its origins in Hughlings Jackson's theory of evolution and dissolution of the nervous system (Jackson, 1894; Levin, 1936). Crow and Wing designate delusions, hallucinations and motility disorders as positive symptoms, believing that they predominate in acute attacks, whether at onset or later. Volitional defect, withdrawal, and flattening of affect are described as negative symptoms and they predominate in the quiescent phases of the chronic stage of the illness. The two categories of symptoms are presumed to reflect ". . . different underlying pathological processes" (Crow, 1980), within the group of schizophrenias. Supporting evidence is afforded by different responses to drug therapy and by other physical measurements.

Positive symptoms in the Jacksonian sense are the result of damage to healthy mental life. This damage leads first to negative symptoms. They are to be found during acute attacks, in the loss of selective attention, the loss of the capacity to discriminate the bodily and

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