PARANOID PSYCHOSIS ASSOCIATED WITH PHENMETRAZINE ADDICTION

DEAR SIR,

A drug-induced psychosis similar to paranoid schizophrenia has been reported as occurring in patients receiving amphetamines (Connell, 1958; McConnell, 1963; Young and Scoville, 1938); Cocaine (Benedetti, 1952; Victor and Adams, 1953); Alcohol (Benedetti, 1952; Victor and Adams, 1953); Bromides (Levin, 1947); and Trihexyphenidyl (Bolin, 1960). There is also a report of a paranoid state occurring in an "immature psychopathic girl" who took more than 10 phenmetrazine tablets a day (occasionally combining this with about 5 glutethemide tablets at night) (Glatt, 1962).

As phenmetrazine usage and habituation are becoming more frequent (Council on Drugs, 1963; Oswald and Thacore, 1963) a further case of paranoid psychosis occurring in a patient on phenmetrazine is of interest.

Case Report

Mrs. C.M., a 42-year-old nursing sister, had been taking phenmetrazine tablets intermittently for 4 years. She stated that she took them in "order to keep awake" and that they "give her a lift". For three months prior to admission she increased her phenmetrazine intake to 12 tablets a day. She had some years previously taken large amounts of methyphenidate and alcohol, but denied having used either during the preceding year.

Her illness started suddenly one night when she "saw" red and green lights flashing amongst the trees. The lights would turn red when she approached them ("a warning") and green when she retreated. During the next few days she decided that she had stumbled across a Communist plot to start a revolution. She developed ideas of reference and persecution, believing that all Africans were "staring at me", "pointing at me" and "following me". A few nights later she "saw" numerous bright torches being flashed among the trees and decided that an attack was to be launched on the nursing home where she was working. That night she went to bed with a pot of pepper and a glass of water at her bedside for her defence. On other occasions she "heard" queer noises around the house, "as if somebody was on the roof, fixing up some electrical gadget". She became convinced that attempts were being made to kill her, and reported the revolutionary plot to the police.

She was seen by a psychiatrist who instituted electroconvulsive therapy and then referred her to this hospital where she reiterated the above story, and remained adamant as to its reality. She denied the possibility that she might be ill, but did not find it strange that she should be alone in her beliefs. She was given thioproperazine 15 mg. a day. After two weeks her symptoms began to recede, and after one month she was symptom-free, although convinced that "there had been something". There was no change after a further month on thioproperazine. All drugs were then stopped. Three months later there were no symptoms of the above psychosis.

This patient had been seen at this hospital a year prior to the current episode. At that time there were no symptoms of schizophrenia and there were no paranoidal ideas. The past history reveals an inadequate sociopathic personality without schizoid or schizophrenic features.

This patient was first diagnosed as suffering from paranoid schizophrenia. In view of the absence of any schizophrenic or schizoid symptoms in the past, and the association between the increased taking of phenmetrazine and the onset of the illness it seems likely that the psychosis was drug precipitated. As with amphetamine-psychosis it is very difficult to separate the illness from paranoid schizophrenia unless there is evidence of drug taking.

Yours faithfully,

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AMITRIPTYLINE AND IMIPRAMINE

DEAR SIR,

I have noted with interest the different findings reported on *re* the efficacy of amitriptyline as an antidepressant. I can perhaps add more light than

heat by noting differences in labelling of various types of depression, which create havoc with the percentages labelled as "good to excellent results", as well as the opposite pole of "poor to fair".

It is apparent that current classifications of depression hardly do justice to the facts of the individual patient. For example, how long does a "reactive" depression remain reactive before it becomes classified as "endogenous"? All depressions must have precipitating causes which are stress-related (perhaps biochemical) but it must be admitted that precipitating events may become quite blurred in the older age groups. Perhaps both Dr. Hoenig and Dr. Browne (Vol. 10, pp. 100–101, July, 1964) can reach some compromise if they could substitute "depression with severe anxiety or agitation" as the type that is helped by amitriptyline. In the U.S.A. this category is often labelled as Involutional Psychosis provided they are in the right age group. These patients obtain both the anti-depressant as well as the tranquillizing properties of amitriptyline. Patients with "retarded" depression, with little to no anxiety, do not do as well with amitriptyline. In addition in "our neurotics", where the need to keep alert (especially in New York) is not only desirable but highly commendable, amitriptyline is usually rejected by the "normal neurotic" because it produces sluggishness, sleepiness or a loss of the "neurotic" drive when the usual dose of 25 mg. tablet is given. I have found that many of these do better with 10 mg. tablets t.i.d. (occasionally with a little Dexedrine added); they then take 50 mg. at night, since amitriptyline is of extreme value in combating their insomnia.

Yours faithfully,

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SYNDROMES OF PSYCHOSIS

Dear Sir,

In his review of "Syndromes of Psychosis" by Lorr, Klett and McNair (July, 1964, p. 605), your reviewer, Dr. J. Hoenig, raises wide questions concerning the reliability of psychiatric diagnosis. Since he was kind enough to mention the study by my colleagues and myself, perhaps I might take up some of his points.

Dr. Hoenig poses a question "What is at fault—the diagnostic scheme or the diagnostician?" As it stands the question is philosophically unwholesome; there can be no schemes outside the minds of the people who use them. But from his remarks attributing the supposedly low levels of concordance to scholastic ignorance on the part of psychiatrists, it would appear that Dr. Hoenig is suggesting that knowledgeable psychiatrists would reach higher levels of agreement than the less erudite. Up to a certain point this may well be correct, in that laymen would presumably achieve lower levels than psychiatrists, and beginners in psychiatry do less well than the more experienced. But beyond a certain point, it is by no means obvious that reliability would continue to increase with increasing knowledge, even if it were possible to say precisely where such "knowledge" is to be found. The belief that "sound men" (those like oneself?) would do better than the generality is of course very seductive, but is quite lacking in proof. There is scope for an interesting, though possibly chastening, investigation.

Secondly, I would suggest that though reliability is undoubtedly important, concern with it can easily be exaggerated. It is perfectly possible to reach high reliability with a quite meaningless system, for all we know the phrenologists (especially the knowledgeable ones) might have agreed to the last man about the presence of the bumps. Validity of diagnosis is surely our major concern, and if this could be achieved, reliability would automatically follow.

Thirdly, I do not accept that the inter-diagnostician levels are as low as everyone seems to assume. To interpret reliability figures correctly one must always bear in mind not only the conditions under which they were obtained, but also whether any particular study aimed to describe a concrete situation or to show what might be achieved under ideal conditions. It is also worth noting that the percentage of agreement can be very simply altered by using different formulae, according to whether one is concerned with agreement regarding the presence of a disorder, or agreement regarding both its presence and its absence. In the following table, for example, agreement could be scored as 33 per cent., or 80 per cent., depending on which definition was used.

		Doctor 1	
		Condition A	Not Condition A
Doctor 2	Condition A ..	10	15
	Not condition A	5	70