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Correspondence

DEPOT INJECTIONS FOR AFFECTIVE DISORDERS

DEAR SIR,

It is now accepted that lithium is effective in reducing the recurrence of manic depressive illness. The success of lithium has meant that there has been little interest in the long-term use of major tranquillizers in prevention of relapses of manic depressive illness. We wish to report five cases where depot preparations of either fluphenazine or flupenthixol have appeared clinically to be of value.

1. A girl aged 17 years had five admissions from 1974 to 1976, suffering from mania, during which time she was treated unsuccessfully with therapeutic levels of lithium. In 1976, she commenced injections of flupenthixol 20 mg every two weeks but lithium was also continued. She remained symptom-free for 2½ years and so flupenthixol was withdrawn and five weeks later she was again admitted to hospital in mania. Flupenthixol was recommenced and three weeks later she was discharged symptom free.

2. A woman aged 57 years had six admissions to hospital between March 1959 and March 1973, on each occasion suffering from mania and after each admission she was discharged on lithium therapy. In March 1973 fluphenazine 25 mg four weekly was added to the lithium therapy. She remained well for 26 months and in June 1975 she stopped attending follow-up and stopped drug therapy. It was known that she soon relapsed but was not admitted to hospital until September 1976. She had two further admissions to hospital with manic attacks over the following year but during this period the patient refused to attend follow-up clinics and refused to take drugs between admissions. In August 1977 she was again started on fluphenazine 25 mg four weekly and lithium therapy was continued and she has remained well since, a period of 15 months.

3. A spinster aged 66 years had a history of 17 admissions to hospital since 1952 with a manic depressive psychosis, predominantly of mixed or manic type. After her 14th admission in 1974 long term maintenance lithium therapy was started. She suffered four separate episodes of mania in the following three years. In December 1977, following her last admission to hospital, she commenced fluphenazine decanonate 25 mg three weekly; since then she has remained well, a period of over one year.

4. A spinster aged 55 years had six admissions to hospital between 1952 and 1975 with manic depressive psychosis of a manic type. Following her last admission, although discharged, she remained chronically manic and was again admitted in March 1976. Then on discharge she was started on fluphenazine and lithium and she remained well for 8 months when fluphenazine was stopped because of 'facial masking'. Five months later she was again re-admitted, manic for a period of three months and was discharged on fluphenazine 12.5 mg every two weeks together with lithium carbonate. At present she remains well, a period of 16 months.

5. A woman aged 57 years had three admissions to hospital between 1971 and 1975. Two of these admissions were with a depressive illness and one a mixed affective state. After her last admission she rapidly relapsed into a psychotic depression with paranoid delusions and was started on fluphenazine injections four weekly. Apart from one mild depressive episode when imipramine was added to her drug regime she has remained affectively well, a period of three years.

Clinically fluphenazine or flupenthixol appear to have been useful in these five patients in preventing relapses of manic depressive illness. This seems unlikely to have been a placebo effect since all patients had a history of frequent recurrences, in three of the patients lithium alone had been ineffective, and discontinuation of the depot preparation in three patients led to their rapid relapse. It is perhaps of significance that manic or mixed states, rather than depression, had been the predominant form of illness of four of the five patients. We would therefore suggest that fluphenazine and flupenthixol may have some role to play in the management of recurrent manic depressive psychoses and certainly merit further investigation.

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HYSTERICAL STUPOR AND DEATH

DEAR SIR,

Hysterical stupor is frequently mentioned but seldom described (Smith, 1978; Merskey, 1979). It accounted for only 10 per cent of a series of stupor in a psychiatric hospital (Joyston-Bechal, 1966). Two cases are presented:—

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1. A Filipino waiter of 38, with three children from a previous marriage to support in his own country, had married an English girl ten years his junior a year before, when he was comparatively fit. Secondarily to hyperuricaemia, he developed progressive, irreversible renal failure, began vomiting and losing weight, and was admitted for the formation of a fistula and to start regular haemodialysis. This implied curtailment of his earning capacity, and he had become impotent: his wife's expectations of a comfortable home and children were unlikely to be realised. He began to improve physically when dialysis was started, his plasma urea going down from 25 to 15 mmol per litre, and he was put on the waiting list for transplant. There was a possibility that his sister would donate a kidney. The patient was friendly, somewhat ingratiating, and apart from some initial insomnia, had no complaints. One morning after his third dialysis he refused to eat his breakfast, and lay with his eyes closed, speaking without moving his lips. He said he would die that night, and to inform his wife. He then stopped all communication, lay mute, motionless, flaccid and unresponsive to painful or other stimulae, neither eating, drinking, nor taking medication. He was catheterised once but passed no urine spontaneously for thirty-six hours. Breathing was almost imperceptible. At this stage, a psychiatric opinion was requested.

Neurological examination, haematological profile and blood chemistry gave no lead, but his pulse rate was 100, increasing to 120 when his wife was mentioned. Without evidence of an organic cause, and no earlier depressive symptomatology, a provisional diagnosis of hysterical stupor was made, and amylobarbitone given through his nasogastric tube. He was incontinent of a large quantity of urine, asked if he was in heaven, and then fell asleep. When he woke up he appeared to be his former cheerful self, eating, speaking and moving normally, and with a memory 'like a dream' for the period of inaccessibility. He continued well, put on weight and went home smiling. There had been no further news from his sister when he returned a month later with a mild infection at the shunt site, and a dramatic tremor in his leg. The latter could be abolished by reassurance, and he was put on a small dose of diazepam. He demanded attention for his tremor, but remained smiling, and persistently denied any other problem. He killed himself by cutting his shunt.

2. An Irishman of 39, working as a clerk, had chronic renal failure due to glomerulonephritis, and the time had come when haemodialysis was necessary. He had two depressive episodes, treated as an outpatient, ten and five years previously, and had decided against the responsibility of marriage because of his nerves. He lived alone but hoped to move in with his brother's family. One day he was unexpectedly irritable with the nursing staff and during his brother's visit became akinetic and mute. Physically he was improving. After 48 hours with no change, he was given intravenous amylobarbitone, and began to talk, move and eat. He claimed to remember nothing of the last two days and did not recognize his brother. After a night's sleep with a hypnotic, his memory returned completely, and he could recall much of what had been said when he was stuporose. He became again a popular joker in the ward, appeared to accept that he could not live with his brother, and progressed well. On the morning he was due for discharge, he had a cardiac arrest and died.

Both men had recently started haemodialysis, a situation of helpless dependency frequently associated with depression, anxiety and suicidal ideation, especially in those over 35 (Kaplan De-Nour, 1979). Possibly their chronically raised blood urea made them more vulnerable to a hysterical reaction of this type. The lesson to be learned from the first case in particular is not to underestimate a patient's capacity for prolonged dissociation from feelings of despair. Symptomatic recovery may be a snare, and hysterical stupor a rehearsal for death.

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THE NURSE'S CLINICAL ROLE

DEAR SIR,

The development of a nurse therapist training scheme described by Dr Bird, Professor Marks and Mr Lindley (*Journal*, October 1979, **135**, 321–9) has a significance extending far beyond behavioural psychotherapy and clinical psychiatry and it is important that it receives the widest possible debate. Professor Marks' impressive pioneering work clearly supports an expansion of the clinical role of the nurse and, by implication, forces other professions to define their particular area of competence more clearly. The two groups most affected by the advent of the nurse therapist in behavioural psychotherapy are obviously clinical psychologists and psychiatrists. Some of the implications for psychologists are mentioned in the paper and no doubt will be discussed by members of that profession. As for psychiatrists, a reappraisal of our sphere of special skills is long overdue; it is a misuse of training if psychiatrists are

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