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Relapse following withdrawal of drug addiction

SIR: There are few published follow-up studies from developing countries on relapse following withdrawal of opiate addiction. I wish to report part of a follow-up study which was carried out on detoxified patients discharged from the Post Graduate Hospital, Dhaka, Bangladesh. The pattern of relapse, effect of group therapy, and probable variables that predict relapse were examined.

Case report. We studied 50 subjects consecutively admitted to the psychiatric unit from December 1987 to July 1988 for detoxification. All were men with a mean age of 28.6 years. In 77% of cases heroin was smoked. Treatment included a two-week withdrawal period with symptomatic medication (chlorpromazine and benzodiazepines) followed by outpatient group therapy for six months. Data were obtained through a questionnaire interview schedule. We measured variables such as peer pressure, causes of relapse stated by patient, family and work situation, type and amount of drugs used in relapse, and physical and sexual difficulties after discharge on a five-point scale.

Subjects were interviewed on admission to the unit before detoxification had begun. The interview covered sociodemographic features including details of drug history. Further interviews were made on the first, third and sixth month following discharge. An operational definition of relapse and abstinence was formulated for the project. We considered relapse as a single use of addiction-forming drugs during follow-up (Hall *et al*, 1991). Abstinence was defined as complete absence of any addictive drug during the period. Only 12 patients voluntarily attended follow-up interviews; information about the rest were obtained by home visits.

By the end of the sixth month, seven subjects remained abstinent. Twenty-eight subjects remained drug free until the one-month follow-up point. At the end of the third month this figure was reduced to less than half (11).

A recent report of outcome by Gossop *et al* (1987) is rather optimistic. Our high relapse rate has to be weighed against the absence of any rehabilitation package. Most patients used less amounts of the addictive drug at relapse than before treatment.

We were interested in the causes of relapse as stated by the subjects. Our results show evidence of peer pressure in 15 (34.88%) of 43 relapses in the form of constant exposure to drug-related cues and offering of drugs (Marlatt & Gordon, 1985). Craving as a cause of relapse was mentioned by another 11 subjects.

Our results, both in terms of the high relapse rate and the psychological factors that may contribute to this, are strikingly similar to those reported from the West and illustrate the truly international nature of the future of opiate addiction.

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Percutaneous endoscopic gastrostomy and severe endogenous depression

SIR: Percutaneous endoscopic gastrostomy (PEG) is a method for obtaining access to the stomach in patients requiring long-term tube-feeding (Bussone *et al*, 1992). The tube is inserted using a gastroscope while the patient is sedated. Since its first description, PEG has become one of the favoured techniques of feeding patients with persistent swallowing difficulty due to neurological or oropharyngeal disorders (Gauderer *et al*, 1980). We recently used this method of feeding in a patient who presented with severe endogenous depression with secondary anorexia and weight loss who improved markedly after electroconvulsive therapy (ECT) after stabilisation of her nutritional status with enteric feeding via PEG.

Case report. A 56-year-old woman was admitted from her home to the psychiatric hospital under Section 2 of the Mental Health Act 1983 with a diagnosis of severe endogenous depression. There was a recent concern by the community psychiatric nurse (CPN) over her poor and intermittent intake of foods and fluids. She had irrational ideas about her digestive processes and her bowels, and nihilistic delusions of what happened to food once she swallowed it. She had lost 19 kg in weight (her body weight was now 32 kg) and her physical state on admission was of marked cachexia and dehydration with a urea concentration of 13.6 mmols/l.

The intensity of her delusion made it impossible to obtain informed consent. A second opinion was obtained from an independent psychiatrist who authorised a course of ECT. Rehydration was started intravenously but her nutritional status continued to decline and she was referred for consideration of parenteral nutrition. It was decided that PEG would be a safer and more effective method of feeding. The

patient's mental state still precluded informed consent and so PEG was implemented under Section 62 as a life-saving procedure.

The patient started enteral feeding under the guidance of the hospital dietitian. The combination of ECT and PEG-feeding resulted in a marked improvement in her physical and mental condition. She was discharged with the tube *in situ*, the district nurse being educated in how to manage the tube, with CPN and psychiatric review. It was decided that the tube would be removed when she attained a certain target weight of 47 kg, and she achieved this in ten weeks. She is now well at six-month follow-up with no depressive ideas and weighs 49 kg.

Feeding via PEG is increasingly used in the UK for feeding patients after stroke and severe head injury. It has occasionally been used for patients with dementia and depression (Bussone *et al*, 1992). It is a simple technique with a 95% success rate for insertion, procedure times of 15–30 minutes, excellent tolerance by the patients (who are often at high risk from surgical procedure), low morbidity (about 6–16%), and with a low procedure rate related to mortality (0–1%) (Ponsky *et al*, 1985; Larson *et al*, 1987). The tubes are concealed beneath the patient's clothing and are therefore cosmetically acceptable and less likely to interfere with rehabilitation. This can be used as a safe and effective method for providing long-term enteral nutrition in patients with eating disorders as an adjuvant to definitive psychiatric treatment maintaining effective nutrition while psychiatric recovery takes place.

We believe PEG feeding should be considered for patients with treatable depressive disorders complicated by cachexia as a safe alternative to nasogastric and intravenous feeding.

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CORRIGENDUM

Journal, May 1993, **162**, 672. The first line of the summary should read "First-degree relatives (FDRs) of 162 schizophrenic and 106 control probands were investigated."

A HUNDRED YEARS AGO

A case of melancholia; sudden illness and death

By FRANK ASHBY ELKINS, MBCMEDIN, *Senior Assistant Physician, Royal Edinburgh Asylum*

A man aged forty-five, married, was admitted to the Royal Edinburgh Asylum on May 25th 1889. A sister of the patient had had an attack of mania and had recovered. He had had a precisely similar attack of hypochondriacal melancholia six years before admission, the symptoms not being quite so severe, and after a year's duration he had recovered perfectly and had remained well for five years. He was a thick-featured, fairly well nourished, rather lymphatic man, with a most woeful expression. He affirmed that nearly every organ of his body was diseased, that his bowels never acted, that he was dreadfully weak and ill, and, in fact, that he was dying. Repeated physical examinations always gave negative results. His bowels were only slightly costive, and it seemed evident that he greatly exaggerated his unpleasant sensations. He was, however, sleepless and he had dyspepsia, as was shown by a furred tongue and by very occasional vomiting, the latter being at least once induced by his putting his finger down his throat. Under treatment he at first rapidly improved mentally and gained in bodily weight; he attended and enjoyed the weekly dances, played lively airs upon his violin and seemed a most promising case. Unfortunately a relapse occurred. Not satisfied with two medical visits a day, he used to send letters to me as well. On Feb. 11th, 1890, he wrote: "I endure unsufferable agony; I fear to perish in this terrible state; I entreat you to examine my stomach and bowels." At that time he had gained twenty-one pounds in weight since admission; he slept fairly, his appetite was good, his dyspepsia was better and he