Brit. J. Psychiat. (1967), 113, 331–332

Correspondence

SIDE-EFFECTS OF PHENOTHIAZINES

DEAR SIR,

The recent letters on the subject of side-effects produced by fluphenazine enanthate should not be allowed to obscure the therapeutic advantages of this preparation. It is the writer's impression that the introduction of this treatment marks the only real advance in pharmacotherapy since the discovery of chlorpromazine. The use of parenteral phenothiazines results in many more dystonic reactions than with the oral preparations. This is particularly so if the patient has had no prior exposure to phenothiazines. Thus, one can anticipate many dystonic reactions at the beginning of treatment. Dystonic reactions take place, as a rule, during the first few days of treatment, and most of them within the first 24 hours. If a patient is in hospital this does not present a problem; in out-patients this would be quite a different matter. However, it has been my experience that in a situation such as this dystonic reactions are unpleasant enough to make the most reluctant patient accept medication, particularly if this is explained to him and his family. Elsewhere ("A long-acting phenothiazine in office practice", *Amer. J. Psychiat.*, 1964, **120**, 1012–1014), we have described an extremely disturbed manic patient and a paranoid patient, neither of whom would take medication but eventually agreed to an injection of fluphenazine enanthate. Both had severe dystonic reactions but agreed to take anti-parkinson medication, and hospitalization was avoided in each instance.

Dr. Barker comments about the onset of later extrapyramidal effects, and suggests that if patients would not take oral phenothiazines they would be unlikely to take oral anti-parkinson medication. This has not been our experience. Many patients take their vitamins, their mineral supplements, etc., on their own, but dislike phenothiazines, not only because they are suspicious of them, but because they have unquestionably unpleasant side-effects. Normally, patients such as these would discontinue the phenothiazines, but when they have no control over this situation they are willing to take anti-parkinson medication. In most cases careful manipulation of the dosage is sufficient to cope with the problem of side-effects, and after the initial weeks of treatment anti-parkinson medication can often be discontinued.

A long-acting anti-parkinson agent would indeed be helpful. However, the main point is that the side-effects have to be balanced against severity of the illness. The dramatic results that are occasionally obtained, the control of previously unmanageable situations, both in and out of hospital, the ability to maintain some patients at home, which was previously not possible, as well as the economy of the treatment, suggest that this preparation has a distinct part to play in the management of a small select group of psychiatric patients. The side-effects, dramatic and disturbing as they may be, would seem a small price to pay for this. It would have been most unfortunate if isolated cases of hypotension had detracted from the widespread use of chlorpromazine in psychiatry.

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DENTAL CARE IN ELECTROPLEXY

DEAR SIR,

With reference to my paper on Dental Care in Electroplexy, Dr. L. G. M. Page in the *Journal* of January 1967, questions the use of a gag at all during this treatment. It was indeed my hope and intention to stress how infrequently a gag is needed during the procedure. Having categorized the three types of dental condition encountered, I emphasized in italics that "in neither of the first two categories, therefore, will a gag be needed".

Similarly, I give reasons based upon dental pathology which to my mind would render a gag imperative, mentioning the partially edentulous patient with either too few or too fragile teeth to withstand the load of the contracting muscles of mastication and those with areas of gum threatened by standing teeth in the opposing jaw.

Dr. Page states he has not used a gag for years. I wonder how he manages the patient with an edentulous upper jaw and a few standing teeth in the mandible—a commonly occurring pattern?

Furthermore, whilst we are agreed that those patients with a full dentition need no gag, Dr. Page

nevertheless advocates the "use of a suitable 'ideal' gag" when partial dentures are left *in situ*. Surely partial dentures merely serve to restore the full dentition—so why use a gag?

Expert advice would be necessary before leaving dentures in place during electroplexy, but if a gag was placed in the mouth as well there would be a very great danger of causing them uneven stress and consequent fracture. The possible sequelae of such an accident are obvious.

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THE GANSER SYNDROME

DEAR SIR,

With reference to Professor F. A. Whitlock's article on The Ganser Syndrome in the January 1967, number of *The British Journal of Psychiatry*, it is now 26 years since I began to seek for cases of this disorder. So far, not one has come my way, in spite of the most varied experience both in the Royal Navy during the last war and in civil prisons since.

One sometimes sees strange syndromes amongst prisoners, but not Ganser. Only a year or two ago I came across a man who gave approximate answers; but he was so clearly a schizophrenic that the full-blown syndrome again eluded me.

Both Professor Whitlock and Dr. Peter Scott are quite right—the Ganser Syndrome is rare in prison practice today: I would go even further, and say very rare.

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MENTAL HEALTH REVIEW TRIBUNALS RESEARCH PROJECT

DEAR SIR,

As part of a research project, psychiatrists, lawyers, patients in mental hospitals or their relatives, and others interested in this topic, are invited to contribute details of their experiences with Mental Health Tribunals.

Letters, which will be treated as confidential, should be addressed to me, c/o Department of Social Administration, The London School of Economics and Political Science, Houghton Street, London, W.C.2.

CYRIL GREENLAND.

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