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FLUPENTHIXOL IN THE TREATMENT OF SCHIZOPHRENIA

DEAR SIR,

For the last few years there has been a considerable increase of interest in the use of depot preparations of fluphenazine for the treatment of schizophrenia (1), and, like most clinicians (2), we have found them extremely effective in our own practice. The most troublesome side effects of these drugs are depression (3) and extrapyramidal symptoms (4). Flupenthixol, a thioxanthene analogue of fluphenazine, is however (Fig. 1) said not to cause depression, and has in fact been used as an antidepressant (5). This drug has been in use for some time in Scandinavia (6, 7, 8) and elsewhere, but is new to most psychiatrists in the U.K. (11). We report here a six-month study of its decanoate as a depot treatment in a group of patients suffering from chronic schizophrenia.

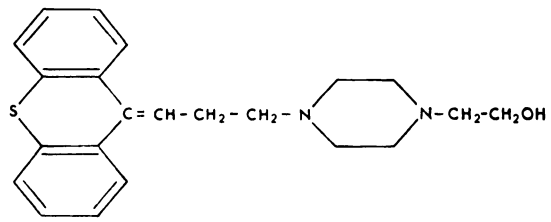

FIG. 1.
FLUPHENTHIXOL

Thirteen female in-patients (average aged 59 years, range 40–75 years) suffering from chronic schizophrenia and resistant to most existing drugs and active rehabilitation, were selected for treatment. They have been in hospital for periods ranging from 7 to 50 years and currently required various tranquillizers (in most instances, fluphenazine decanoate in a dosage ranging from 25 mg. once weekly to once every three weeks) together with orphenadrine citrate 50 mg. thrice daily and, in most instances, also oral tranquillizers on an intermittent dosage basis depending on their degree of psychotic disturbance from time to time. Ten of the thirteen were having fluphenazine decanoate 25 mg. every 2 weeks and two were, in addition, having Majeptil, and five others thioridazine orally. One patient was being treated with trifluoperazine only, and two others with haloperidol, all in fairly high dosage.

On induction into the trial, all the patients had flupenthixol decanoate substituted for their fluphenazine decanoate or other 'basal' tranquillizer at a dose of 20–40 mg. every 1 to 3 weeks. In seven cases 40 mg. every 2 weeks proved best, and six patients needed 40 mg. weekly given in the usual way by deep i.m. injection. Any concurrent oral medication was left unaltered, as one object of the trial was to keep other medication, 'milieu' and nursing and medical attention as constant as possible over a six-month period. After two weeks our routine prescription of orphenadrine citrate was discontinued, and five of the thirteen patients were able to tolerate its discontinuation without developing extrapyramidal signs. Full haematological and liver function tests were carried out on all patients before the trial and after six months. All results remained within normal limits. Patients were rated at 2, 4, 6, 8, 12, 16, 20 and 24 weeks on a Wing Rating Scale (9) for chronic schizophrenia in the dimensions of 'Hallucinations', 'Delusions', 'Withdrawal', 'Speech Disorder', 'Affect' and 'Behaviour'; these ratings being carried out by doctors and with the help of nurses who knew the patients well and were therefore relatively sensitive to nuances of change for the worse or the better.

Other than some mild extrapyramidal effects in three patients—akathisia in one, 'pill rolling' tremor in another and drooling in a third—easily controlled by our usual anti-parkinsonian drugs—no local or systemic side effects were found, and in particular no evidence of depression. On the contrary, no less than 11 of the 13 patients reported spontaneously (and showed) a significant elevation of mood and were 'more cheerful', 'brighter' and 'more energetic' (in two patients, to the extent that the drug had to be discontinued!). Both of these patients (one after 6, the other after 8 weeks) became elated, eventually developing hilarious overactivity and punning and 'clanging' speech to an extent which amounted to a manic reaction; this subsided within a week or two of discontinuing the drug. Flupenthixol has been reported as an effective antidepressant (10), and our experience suggests it may well be one. So far as the drug's antipsychotic efficacy was concerned, in even

AVERAGE WING RATINGS
(Thirteen patients)

Wing scale	Pre-trial	Weeks of treatment							
		2	4	6	8	12	16	20	24
Hallucinations	2·5	2·9	2·7	2·1	1·7	1·7	2·0	1·9	2·1
Delusions	2·5	2·5	2·5	1·9	1·7	1·2	1·7	2·0	2·1
Withdrawal	2·5	2·2	2·2	1·8	1·7	1·7	1·7	1·7	1·8
Speech disorder ..	2·5	2·5	2·5	2·2	2·5	2·2	2·0	1·9	2·1
Affect disorder	3·9	3·9	3·9	3·1	3·3	2·9	3·0	2·9	3·2
Behaviour disturbance ..	3·0	3·0	2·9	2·0	1·9	1·5	1·7	1·6	1·6

FIG. 2.

these very chronic 'refractory' patients the results were excellent in that 10 patients showed a clear clinical improvement (possibly in part from a degree of 'subclinical' depression), two as stated, became manic and only one patient's rather tense and hypochondriacal behaviour did not improve.

Although this was by way of a pilot study and therefore uncontrolled, it would have been impracticable and unjustifiable in our view to use placebo in these patients. Seen in conjunction with the results reported by other workers (6) we believe ours to be clinically realistic. Fig. 2 summarizes our Wing ratings of the patients before and during the trial.

Schizophrenic patients are, of course, highly responsive to changes in their environment (9), but we doubt whether an air of expectancy alone would explain our results; indeed, our initial attitude was, if anything, one of scepticism. We feel that flupenthixol decanoate is a promising and interesting drug which, rather to our surprise, improved a group of our most chronic schizophrenics to a degree much beyond what we had been able to achieve with what we considered to be fairly sophisticated chemotherapy with other drugs, and we believe it may become not only a valuable therapy for patients suffering from schizophrenia but perhaps even the first depot antidepressant. Further trials in both schizophrenia and depression seem indicated.

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DEPERSONALIZATION

DEAR SIR,

Much of the research carried out on depersonalization has involved assessments of its incidence in a variety of psychiatric and non-psychiatric populations. Authors have not always made it clear that there are a number of factors that may affect such estimations. These include: the definition of depersonalization accepted for the study, the method of eliciting the phenomenon, the skill of the interviewer, the validity and reliability of the method adopted, the co-operation and suggestibility of the subject, and the influence of direct questioning, suggestion and contagion.

Not one of the definitions recorded in the literature is entirely satisfactory; some just comprise a list of symptoms described by depersonalized subjects. With a phenomenon so difficult to delineate this is perhaps not surprising, and Lewis (3) pointed out