

Clozapine-treated NMS

SIR: Having recently experienced difficulties treating a floridly disturbed young schizophrenic man who had previously had two episodes of neuroleptic malignant syndrome (NMS), we felt it may be helpful to others in this predicament to report our experience with clozapine.

Case report. The patient was a 35-year-old man with an 18-year history of schizophrenia, which for some years had been resistant to a broad range and dosage of established antipsychotics, therapeutic only in that he was a little more in touch with reality and his behaviour rather less disturbed. He had needed several periods of treatment in the secure unit, for unprovoked assaults in his District General Hospital ward. He was receiving treatment with zuclopenthixol (1000 mg weekly), chlorpromazine (200 mg q.d.s.), and procyclidine (5 mg t.d.s.) when he developed NMS characterised by pyrexia, rigidity, flushing, sweating and agitation with some apparent confusion. Creatine phosphokinase (CPK) levels were significantly elevated (up to 1467 IU/L). His antipsychotic medication was stopped and the NMS abated. He remained settled for a number of weeks but his psychosis returned and required treatment. It was felt that chlorpromazine was worth trying cautiously, but he developed a recurrence of NMS, and all antipsychotics were stopped. Following recovery from NMS, his mental condition deteriorated rapidly with florid delusions, severe thought disorder, and grossly disordered behaviour and aggression, necessitating transfer to the secure unit and treatment in seclusion for an extended period. General sedation with phenobarbitone and benzodiazepines was unsuccessful. We were faced with a difficult dilemma, in that he needed urgent antipsychotic treatment but stood the risk of recurrence of NMS. In view of the recurrence with chlorpromazine, it was felt that most of the well-established drugs were not acceptable (Susman *et al*, 1988), and in view of its different chemical structure and pharmacological profile (Coward *et al*, 1989), a decision was made to commence the patient on clozapine, with the usual precautions, plus observations with a view to detecting NMS. Over a period of seven weeks the patient improved markedly in behaviour, thought and contact with reality, and regained some of his emotional warmth. He is as well as he has been for several years, has shown no signs of a recurrence of NMS, and is well enough to return to the open ward.

Apart from being consistent with reports that clozapine is effective in resistant cases who have not responded to other established medication (e.g. Kane *et al*, 1988) this case suggests that clozapine is a drug to consider when a patient has suffered NMS.

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KANE, J., HONIGFELD, G., SINGER, J., *et al* (1988) Clozapine for the treatment of resistant schizophrenic. *Archives of General Psychiatry*, **45**, 789–796.
SUSMAN, V. L. & ADDONIZIO, G. (1988) Recurrence of neuroleptic malignant syndrome. *Journal of Nervous and Mental Disease*, **176**, 234–241.

All-night television can damage your health

SIR: Patients with chronic schizophrenia often reverse the more usual night/day pattern of sleep and activity. This enhances their social withdrawal and hinders attempts to engage them in rehabilitation programmes. The provision of all-night television on the independent channels since August 1987 reinforces this behaviour and can have deleterious effects on the mental states of patients if, as a result, they fail to comply with, or attend for, medication. The following case report illustrates how all-night television watching led to a self-limiting symptomatic relapse.

Case report. A 31-year-old Afro-Caribbean male who lived with his parents and sister and who had a 10-year history of paranoid schizophrenia was symptom-free on a weekly depot and twice-daily oral anti-psychotic medication. He attended a day hospital where he received his medication and attended workshop facilities. His generally excellent attendance at the day hospital declined and he regularly missed the mornings, arriving between 1.00 p.m. and 3.00 p.m., complaining of feeling tired. Under close questioning he admitted that he had started watching all-night television until 5.00 a.m. He missed doses of his prescribed oral medication and for some weeks he also missed his depot and started to complain of unpleasant auditory hallucinations. When confronted with his poor attendance and compliance and advised to go to bed earlier so that he could attend a full day at the day hospital, he refused, saying that he enjoyed the selection of programmes available overnight and was not prepared to miss them. After six weeks of poor attendance and missing doses of medication he began to experience auditory hallucinations emanating from his television set, and to feel that people on television were interfering with his thoughts. These experiences made television watching intolerable and, consequently, he began to retire to his bed earlier. His attendance at the day hospital improved to that his prescribed medication could once again be given under supervision, and his symptoms disappeared.

When patients with day/night reversal fail to attend out-patient or day hospital facilities, or sleep through their medication times, enquiries should be made as to how the individual is spending his nocturnal waking hours. If a fondness for all-night television contributes to the problem, appropriate counselling can be tried but may fail, as in this case. Perhaps the television companies should strive to improve the quality of broadcast material during normal waking hours!

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Toluene-related psychosis

SIR: Further to previous correspondence on this subject (*Journal*, 1989, 155, 132), we would like to address the issue of toluene-related psychosis in the context of solvent abuse. The patient cited in the history below has previously been mentioned in your columns, as he has frequently required treatment for psychotic symptomatology related to inhaling adhesive mixtures.

Case report. A young native Canadian male was readmitted to our unit in a dishevelled state, having been found wandering by the local police. At interview he was disorientated and tremulous, and displayed oculogyric symptomatology. He could give no history at that time. His clouded consciousness precluded full mental state evaluation. He

was commenced on chlorpromazine (50 mg twice daily), and benztropine was administered to control his oculogyric symptoms.

The patient settled quickly, and within 72 hours his behaviour was quite appropriate at interview, showing no signs of paranoia or disorientation. He revealed that he had changed his brand of solvent, and was now inhaling paint-thinner instead of adhesives. He was fit for discharge within one week of admission, is currently abstaining from solvent inhalation, and is on no medication.

It is notable that this patient settled so quickly on this admission, having previously required months of hospital treatment for episodes of paranoid psychosis related to solvent abuse. The solvent he inhaled prior to this admission was acetone-based, and his clouding of consciousness was short-lived. The inhalation of toluene-based adhesives had previously produced a definite paranoid psychosis in this man, but no such condition was evident on this admission. We suggest that toluene was the agent responsible for the paranoid psychosis in his case; the lipophilic nature of the substance, and its slow excretion from brain tissue, producing a much more protracted cerebral disturbance. We feel that toluene inhalation was a cause of paranoid psychosis, and that extensive inhalation may have major neuropsychiatric consequences.

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A HUNDRED YEARS AGO

Music as a remedy

Most of us have at one time or another been convinced by personal experience of the fact that perception of pain and of grief depend in great measure on our mental attitude for the time being. It grows under observation, wanes if neglected, and is even obliterated for a time if our emotions are strongly acted on by some shock or counter attraction. It is clearly in this way that we must explain the anaesthesia of hypnotism and the soothing effects of harmony in sound. This very sense of calm has, moreover, as a form of rest, a distinctly curative tendency, so that music may to this extent be regarded as a remedy in illness. The ancient healers understood this, and we find accordingly that hardly any prescription or course of treatment was by them regarded as efficacious unless agreeably combined with the allurements of melody or quaintly blended with an incantation. Egyptians, Indians, Greeks, and Romans in

turn wooed in this manner the *vis medicatrix*, and, we cannot doubt, with a fair measure of success. It need hardly excite comment, therefore, that the same attraction of melody has been credited in our own days with a curative property. One of the latest notes on this subject is one which applauds music as an anodyne in gout. The reference, of course, is to the pain endured rather than the malady which occasioned it. This latter is beyond the control of merely neurotic forces. What refinements of molecular change in the sensorium underlie the anaesthesia so readily induced there is as yet no evidence to show. Whatever their nature, however, we may take it for granted that they do occur, and the process which gives rise to them is perhaps not altogether unworthy of experimental use now and then by the modern practitioner.

Reference

Lancet, 25 April 1891, 951.

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