carcinoma in situ of the cervix. The first follow-up smear taken from the vaginal vault five years later, in December 1970, revealed malignant squamous cells. Biopsy of selected areas of the vagina revealed a microinvasive carcinoma arising in the vaginal vault. Cytoscopy, I.V.P. and barium enema were normal. The patient was treated by applying a plaque containing 50 mg. of radium for 72 hours to the vaginal vault. The patient remains well and free of any further recurrence.

Case 2

Mrs. B. L., age 51, had a vaginal hysterectomy and vaginal wall repair in 1963 for uterine prolapse, cystocele and rectocele. The extirpated specimen revealed a carcinoma in situ of the cervix. The patient was not seen again until June 1970, when she complained of vaginal bleeding. Examination revealed a large central palpable mass, freely movable but adherent to the bladder. Biopsy showed an infiltrating squamous cell carcinoma of the vaginal vault. Cytoscopy revealed the tumour mass to be invading the bladder. Intravenous pyelogram and barium enema were normal. An anterior excision, vaginectomy, pelvic lymph node dissection and formation of an ileal bladder. Biopsy showed the remainder of the cervix to be invading the bladder. Intravenous pyelogram and barium enema were normal. An anterior excision, vaginectomy, pelvic lymph node dissection and formation of an ileal bladder. Biopsy showed the remainder of the cervix to be invading the bladder.

In March 1971 the patient was submitted to repair of a perineal hernia. Three nodules removed at the site of the hernial sac revealed squamous cell carcinoma. Clinically the remainder of the pelvis felt normal. This patient looks and feels very well, but obviously her prognosis is very guarded.

Carcinoma in situ of the cervix recurs at the vaginal vault because of operative techniques that have not removed sufficient vault epithelium adjacent to the cervix. Failure to recognize that these early lesions may spread to the vaginal vault has resulted in a recurrence at the vaginal apex either as a carcinoma in situ, or as an early invasive carcinoma. Because of the multicentricity of carcinoma in situ, cancerization of the entire female genital tract may occur. It is therefore mandatory that all patients be followed up with cytology after any method of management.

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Amotivational syndrome

To the Editor:

I was very interested to read the article “Amotivational syndrome: The real management problem of schizophrenia” by W. N. Andrews and M. H. King (Can Med Assoc J 106: 1208, 1972).

Since 1964 we have been providing total community care for the mentally ill for a population of 100,000 spread over 15,000 square miles. The area is divided into five geographical regions and each one is looked after by a team consisting of a community nurse, a social worker and a psychiatrist. We also have a 60-bed inpatient unit to deal with severely ill patients and acute crisis situations. The therapeutic team approach has been effective and successful in the treatment of chronic psychotics. At present 83 patients are on regular injections of fluphenazine enanthate (Moditen). Apart from drug-induced parkinsonism, the most common side effect that I have noticed is depression of mood. Twenty-five of my patients are on antidepressant drugs along with Moditen. This depression responds quickly to antidepressant drugs such as Surmontil, Parnate, Nardil and/or three or four applications of electroconvulsive therapy.

I wonder if some of the patients who are described as having the amotivational syndrome are missed cases of depression caused by the administration of long-acting phenothiazine drugs?

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Psychiatric Centre,
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Yorkton, Sask.

To the Editor:

Dr. Ray is apparently referring to patients in the diagnostic category of schizo-affective disorder. Patients with this type of disorder who have responded well to fluphenazine enanthate in combination with short-term electroplexy, maintenance of electroplexy or antidepressant drugs and who do not require a program of the behaviour modification type are included in my first group (20%). In this group fluphenazine enanthate appears to have an antidepressant action. In the study at the London Psychiatric Hospital, however, between 70% and 80% of the 160 patients whose psychotic symptoms had disappeared on fluphenazine enanthate therapy were reluctant to assume a level of responsibility in the community appropriate to their age, education and intellectual capacity.

It is noteworthy that the long-acting tranquilizer offers the clinician the opportunity to do more than just keep patients out of hospital. The person with the amotivational syndrome is an under-achiever and a psychiatric team is faced with a challenging task of working through a multi-level treatment program in order to help the patient make significant progress towards self-actualization. In the early stages of this treatment continuum, patients get little positive emotional feedback from the environment and may appear gloomy and anxious; antidepressant drugs produce little change and any benefit from electroconvulsive therapy is of a temporary nature. The recognition of the amotivational syndrome and the frequency of its appearance are likely to bear a close relationship to the treatment goals and levels of expectation held by the psychiatrist and his team.

In the management of 160 schizophrenic patients, mainly from urban areas, whose treatment included a five-year program of regular fluphenazine enanthate injections, the startling fact has emerged that a high percentage of these patients are reluctant to return to, or remain in, the world of reality with its attendant responsibilities.

My first thoughts about the amotivational syndrome arose in the course of my attempts to deal with these challenges during my three years in the mid-60s as clinical director of the Yorkton Psychiatric Centre.

London Psychiatric Hospital,
London 25, Ont.

BCMA annual meeting

To the Editor:

I am writing to congratulate the Journal on its reporting of the BCMA Annual Meeting held in Penticton from May 24-27 (Can Med
Indications—Sustained essential hypertension.

Dosage Summary—Therapy with 'ALDORIL' or 'ALDORIL*-15 should generally begin with 25 mg twice daily and be increased usually in intervals of 25 mg after four or more days or when blood pressure control is inadequate. Occasionally, the initial single daily dose of 'ALDORIL' will provide a smooth transition in therapy. The dosage of 'ALDORIL' or 'ALDORIL*-15 should be limited initially to 25 to 50 mg daily, and increased, if necessary, to levels usually between 50 and 200 mg of hydrochlorothiazide.

 Approaches to Replacement Therapy—Therapy with 'ALDORIL' may be initiated in most patients already on treatment with other drugs. By decreasing initially the dosage of ganglion-blocking agents and of guanethidine by 50 percent and by subsequent gradual withdrawal, the gradual addition of 'ALDORIL' will provide a smooth transition in therapy. The dosage of 'ALDORIL' or 'ALDORIL*-15 should be limited initially to 25 to 50 mg daily, and increased, if necessary, to levels usually between 50 and 200 mg of hydrochlorothiazide.

Fluorescence in urine samples at wave lengths of light may be reported at a wavelength of 365. This will interfere with the diagnosis of pheochromocytoma. Methyldopa will not serve as a diagnostic test for pheochromocytoma.

Hyponatremia may be observed or may occur in critical illness, particularly in patients with renal or hepatic disease, or with inadequate electrolyte intake. Diuretics may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypokalemia may develop (especially with diuretics) in severe cirrhosis with concomitant stator or alkalosis, or with inadequate electrolyte intake. Hypokalemia may occur or develop by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride defect may be corrected by use of ammonium chloride (except in patients with hepatic disease) and in patients with metomio acidosis or the metabolic acidosis of diabetic ketoacidosis. A low salt diet may occur if dietary salt is unduly restricted, especially during hot weather.

Tachyphylaxis may increase responsiveness to sympathomimetic drugs, including ephedrine. The anti- hypertensive effect of the drug may be enhanced in the post-sympathetic patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics.

Pathological changes in the pancreatic glands with hypercalcemia and hypophosphatemia have been described in rare cases. Neurological Symptoms associated with effective lowering of blood pressure include lassitude, light-headedness, and symptoms of cerebrovascular insufficiency. Seizures, usually appearing during initial therapy or when dose is increased; similarly, headache, asthma, or weakness may be noted as early, but transient symptoms. Rarely reported: paranoid ideation, psychoses, psychic disturbances including nightmares, reversible mild psychoses or depression, and a single case of bilateral Bell's palsy. Gastrointestinal: Occasional reactions generally relieved by dose decrease: mild dysaesthesia of the mouth and gastrointestinal symptoms including, distention, constipation, flatulence, and diarrhea; rarely, nausea and vomiting. Rarely reported: positive direct Coombs test, acquirable hemolytic anemia, leukopenia, rare cases of thrombocytope尼亚. Toxic and Allergic: Occasional drug related fever and abnormal liver function studies, and a rise in BUN. Rarely, mild and reversible jaundice, skin rash, sore tongue or "black tongue." Adverse Reactions—Methyldopa—Cardiovascular: Angina pectoris may be aggravated; reduce dosage if symptoms of orthostatic hypotension occur; bradycardia may occur.

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