alcoholism" among ambulant patients is fraught with great danger. Apart from drinking on top of the drug with additive (and possibly potentiating) effects—for example, on driving—there is the danger of developing psychological and, more rarely, also physical dependence.²⁻⁵ For this reason we advocated in 1965 the use of this drug in the treatment of the alcoholic withdrawal phase for no longer than six days.⁶

Our experience over the past 12 years confirms the view of many Scandinavian and German observers that chlormethiazole is probably the drug of choice in severe alcohol withdrawal syndromes, in particular delirium tremens. It should, however, be used for inpatients only and for no longer than six or seven days (except in cases of delirium tremens, as the type of alcoholic prone to develop delirium tremens seems to have a lesser tendency to misuse other drugs). Chlormethiazole should not be used for the long-term treatment of alcoholics. The risks limiting the long-term use of this drug in alcoholics and the emotionally unstable because of their "dependency-proneness" do not seem to apply to the treatment of insomnia, agitation, etc, in the elderly, in whom the drug has been found to be very useful by various observers.⁵

M M GLATT

St Bernard's Hospital,
Southall, Middx

¹ Glatt, M M, *A Guide to Addiction and its Treatment—Drugs, Society and Man*. Lancaster, MTP, 1974.

² Kryspin-Exner, R, *Wiener medizinische Wochenschrift*, 1971, **121**, 811.

³ Reilly, T M, *British Journal of Psychiatry*, 1976, **128**, 375.

⁴ Alsen, M, *British Journal of Addiction*, 1975, **70**, suppl 1, p 53.

⁵ Glatt, M M, Lecture, 22nd International Institute on Prevention and Treatment of Alcoholism, ICAA, Vigo, Spain, 1976.

⁶ Glatt, M M, George, H R, and Frisch, E P, *British Medical Journal*, 1965, **2**, 401.

Clonazepam in treatment of tardive oral dyskinesia

SIR,—In view of the recent use of benzodiazepine drugs in the treatment of tardive oral dyskinesia¹⁻³ the following may be of interest.

Eighteen patients suffering from tardive oral dyskinesia due to the previous administration of antipsychotic drugs for schizophrenia were treated with clonazepam as part of a straightforward clinical trial. The trial was not double-blind, nor was there any attempt to modify other medication. The patients, all but one female, ranged in age from 36 to 75 years, the mean being 60.8 years. They had been exposed to antipsychotic drugs for 2-17 (mean 6.8) years.

Full details of previous psychiatric history and treatment were available in all cases. Initial assessment included careful observation of the movement disorder and discussion with the patients regarding their appreciation of the disorder, their attitude to it, and their ability to exercise control over it. Some patients kindly agreed to have their movements photographed with a rapid-sequence camera. Routine full blood count and liver function tests were undertaken before the start and at the end of the trial in view of a report³ of thrombocytopenia occurring during treatment with clonazepam.

A simple dosage scheme was initially arranged, starting with a total dose of clonazepam of 1.0 mg daily for the initial two days

and increasing by 1.0 mg per day every alternate day until a maximum of 4.0 mg per day had been achieved. Patients were assessed at weekly intervals and adjustments made to the treatment programme where necessary.

In no case were the involuntary movements either completely removed or made worse by clonazepam. There was noticeable improvement in two cases and slight improvement in nine, with no change in the remaining seven.

The incidence of side effects was high, there being a marked tendency to drowsiness, which progressed to unfavourable levels in six cases, with behavioural changes, confusion, and ataxia, particularly in the most elderly patients. Other side effects included increased Parkinsonism, rash, blurred vision, and ankle oedema. Haematological findings were negative other than that before treatment five patients were discovered to have moderate microcytic anaemia.

The overall clinical impression was without doubt one of disappointment; although there was improvement in eleven cases out of 18, in nine of these the improvement was considered to be marginal only and when measured against the high level of intolerance did not suggest to the clinician to be a worthwhile therapeutic effect. The most worrying feature of the trial was without doubt the severe level of intolerance even on low doses, particularly in the most elderly patients. One might go so far as to state that the drug should not be used in patients over 65 without the utmost circumspection, bearing in mind that there is ample evidence to suggest that tardive dyskinesia is not only related to the length of exposure to antipsychotic drugs but also to the age of the patient, so that it is in these elderly patients that there will be attempts to provide therapeutic relief. The present trial did not include sufficient younger patients to test tolerance fully in a younger population, in which the drug might prove to be of more value. The two patients in whom clonazepam was relatively successful were in their mid-fifties, but one patient of similar age showed such severe intolerance that the drug had to be stopped.

Clonazepam does therefore not seem to be a substance which should be prescribed as a likely drug to control tardive dyskinesia, but might be worth considering in selected patients, preferably under 60 years of age and if possible as inpatients so that careful monitoring of behaviour can be maintained.

G SEDMAN

Herbert Day Hospital,
Bournemouth

¹ Jus, K, *International Journal of Clinical Pharmacology*, 1974, **9**, 139.

² Korczyn, A D, and Goldberg, G J, *British Journal of Psychiatry*, 1972, **121**, 75.

³ O'Flanagan, P M, *British Medical Journal*, 1975, **1**, 269.

⁴ Veall, R M, and Hogarth, H C, *British Medical Journal*, 1975, **4**, 462.

Plight of Chilean doctors

SIR,—I have just had very disquieting news about two Chilean members of the medical profession who have "disappeared." The details are as follows:

(1) Dr Ivan Inzunza, 42 years old, married with one child. He is a gastroenterologist and qualified in 1960. He was director of the National Health Service for Employees during the Allende administration. He was working

as a doctor until 4 August 1976, when he suddenly disappeared.

(2) Dr Carlos Godoy, 39 years old, married with three children. He is an obstetrician and qualified in 1960. Worked in the National Health Service during the Allende administration. At present works in the Hospital de San Bernardo. He left the hospital on 4 August to go to a health centre but never arrived there.

The Chilean authorities claim that they know nothing about them, but this is a method which they have used in the past to try to prevent further inquiries. Past experience has shown that if doctors from this country make inquiries from the Chilean authorities or the Colegio Medico de Chile there is a possibility that they may be released by the authorities and at least permitted to emigrate.

MARGOT JEFFERYS

Department of Sociology,
Bedford College,
London W1

Travellers' diarrhoea

SIR,—To what extent does travellers' diarrhoea occur in the United Kingdom? You believe it to be rare in Britain (14 August, p 385) but add thoughtfully that perhaps some of our visitors do suffer but politely do not mention it.

Of 485 persons who replied to a questionnaire after attending a congress in London in September 1974, diarrhoea was experienced by 4 (2.8%) of 143 British residents and 2 (0.6%) of 342 visitors from abroad. This extremely low incidence of travellers' diarrhoea contrasts with a high incidence reported in travellers from countries with cool climates and North European standards of hygiene to countries where these conditions do not hold—for example, Mexico (29%¹ and 49%²) and Tehran (40%³). I agree that washing the hands after visiting the lavatory would help to reduce spread of the disease. Routinely washing the hands before meals might help avoidance.

B J FREEDMAN

Dulwich Hospital,
London SE22

¹ Gorbach, S L, *et al*, *New England Journal of Medicine*, 1975, **292**, 933.

² Merson, M H, *et al*, *New England Journal of Medicine*, 1976, **294**, 1299.

³ Kean, B H, *Lancet*, 1969, **2**, 583.

SIR,—In your leading article on this subject (14 August, p 385) you state that "in Bognor or Blackpool the hazard is small, but in Bombay or Bangladesh the attack rate may reach 100%" and that in Mexico City one-fifth of the delegates to the gastroenterology conference were confined to bed.

While I have never lived in Mexico, experience in various Asian cities prompts me to suggest that such high figures may be caused by lack of local knowledge. For example, you suggest that bottled drinks are safe. Some are and some are not. Coca Cola is prepared in the same way everywhere. The water is first hyperchlorinated and then dechlorinated. On the other hand I investigated a factory in one of the principal cities of India which makes a brand of drinks served in the best hotels. Untreated tap water was used. Woe to the gastroenterologist who