community survey of Distalgesic poisoning and thereby illustrating its true morbidity, mortality, and prevalence, we hope to have contributed to this end. Our results clearly indicate that in our area Distalgesic is now the principal cause of self-poisoning fatalities. This finding must surely be viewed in conjunction with the fact that there remains no conclusive evidence that this drug has any superior analgesic efficacy when compared with other manifestly less dangerous alternatives.

ROBERT J YOUNG

Diabetic Department,
Royal Infirmary,
Edinburgh EH3 9YW

A A H LAWSON

Milesmark Hospital,
Dunfermline KY12 9NR

Addiction to Distalgesic (dextropropoxyphene)

SIR,—I am frankly astounded to read that a patient with addiction to dextropropoxyphene was given methadone during the withdrawal phase, as reported by Dr Robert Wall and others (17 May, p 1213). Why could the patient not have been allowed to withdraw from the dextropropoxyphene without complicating matters by using another, even more highly addictive, substance?

Our "detox" unit in this city treats many cases of withdrawal from diazepam, heroin, dextropropoxyphene, etc; and it has rarely been shown necessary to complicate the picture or postpone the suffering by adding other drugs.

N MELLOR

Drug and Alcohol Rehabilitation
Society,
Victoria,
British Columbia V8W 1M8,
Canada

* *We sent this letter to Dr Wall, whose reply is printed below.—ED, *BMJ*.

SIR,—Dr Mellor raises an interesting point concerning the use of substitute narcotics in the treatment of opiate-type dependency. Methadone is now widely used to deal with the abstinence symptoms of opiate withdrawal. Dextropropoxyphene produces dependency of this type whose severity is reflected in the amount consumed and length of time of abuse. Our patient had attempted many times to withdraw from Distalgesic. She had tried sudden and gradual withdrawal without success. There was some concern about the abnormal findings in liver function tests and subsequent liver biopsy. These were no doubt due to paracetamol toxicity and made it unwise to use Distalgesic on a reducing scale to effect withdrawal.

This patient had undoubted dependency and proved inability to curtail her abuse. In order to ensure her compliance in a treatment programme she was placed on low and diminishing doses of methadone for a limited period of time and under strict clinical supervision. As was to be expected, the small dose of methadone ameliorated her withdrawal symptoms and ensured her co-operation in the early stages of treatment, which are often distressing to the patient. During several months of outpatient follow-up she did not resort to abusing Distalgesic or any other drug and she was discharged from this unit.

The point here is that sudden withdrawal may be effective in treating true addiction in highly motivated patients with mild-to-moderate dependency. However, there is a risk that treatment will be stopped and abuse resumed if the abstinence symptoms experienced are deemed by the patient to be too distressing. Methadone is of lower addictive potential than most other narcotic drugs; hence its use in treating opiate-type dependency. The dose used in this case was at least half that commonly used in effecting opiate withdrawal, was given on a rapidly reducing schedule, and was given for a very short period of time. The risks of developing dependency on methadone were therefore negligible.

ROBERT WALL

Regional Addiction Treatment
Unit,
All Saints Hospital,
Birmingham B18 5SD

Adverse reactions to D-penicillamine after gold toxicity

SIR,—We were interested to read the article by Dr M J Dodd and his colleagues on adverse reactions to D-penicillamine after gold toxicity (21 June, p 1498).

We have looked at our own figures for patients developing gold toxicity and then starting treatment with penicillamine. Out of a total of 26 patients, 13 started penicillamine within six months of stopping gold therapy. Only one of these patients developed a reaction while on penicillamine (rash with gold and thrombocytopenia with penicillamine). The other 13 patients started penicillamine six months or more after stopping gold and four developed an adverse reaction.

The total incidence of adverse reactions (5/26) compares with an incidence of 8/44 for our patients on penicillamine without prior gold therapy. We conclude from our figures, firstly, that there is no increased incidence of adverse reactions to penicillamine in patients who have had an adverse reaction to gold and, secondly, that there is no increased risk if the penicillamine is started within six months of stopping gold therapy.

A detailed table is available on request.

P J SMITH
W R SWINBURN

Rheumatology Unit,
Wrightington Hospital,
Wigan, Lancs WN6 9EP

Prescribing psychoactive drugs to addicts

SIR,—Dr Thomas Bewley in his article (16 August, p 497) draws attention to the need for doctors in private practice to be particularly aware of the pitfalls which may occur in respect of prescribing psychoactive drugs to addicts. However, I believe that I speak for the main body of private physicians when I say that we are intensely aware of these problems—to such an extent that for most of us the situation does not arise in the context of agents which are controlled under the Misuse of Drugs Act.

What presents far greater difficulty in everyday practice is the problem of patients who request prescriptions of certain other drugs, including appetite suppressants such as

diethylpropion and other types of sedatives quite apart from the barbiturate group. Indeed, after some three years in full-time private practice I have become so concerned about this that I have made some early moves to develop a private doctor's forum whereby such problems could be mutually discussed; thus I could envisage the establishment of some form of register whereby that all-too-familiar patient could be confidentially registered and thus identified early on presentation. All of us must have had the suspicion that there is a nucleus of such drug abusers who will foist themselves on one physician after another, procuring psychoactive drugs and changing doctors as soon as the going gets rough.

Certainly more open discussion and widespread education of doctors concerning the best ways of handling patients at this particular interface must result in the profession acting with united policy to serve the best interests of the patient who behaves in such a manner; and, while there unfortunately will always be those who will compromise the professional ethic for fiscal reasons, a forum such as I have proposed should also serve to minimise any aspersions that private doctors in general are a soft touch for whatever drug a patient may ordain for himself.

MARTIN SCURR

London SW3 1RH

Disturbed behaviour induced by high-dose antipsychotic drugs

SIR,—We read with interest the report by Dr T R E Barnes and P K Bridges on disturbed behaviour induced by high-dose antipsychotic drugs (26 July, p 274). We would like to make the following comments.

(1) The disturbed behaviour described in the three reported cases was characterised by excitement, restlessness, and aggression. The behaviour is more likely to be due to akathisia, which is known to occur in patients on high doses of antipsychotics, than to a relapse of these patients' schizophrenic illness. The authors themselves stress that the symptoms were "atypical for the patient."

(2) Two of the patients reported improved on reduction of the dose of antipsychotics and one of them needed big doses of anti-Parkinsonian medication throughout. The third patient settled down slowly as the blood level of flupenthixol gradually decreased and the drug was replaced with haloperidol, which probably acts on a different site. These observations support our claim that the behaviour described is consistent with a known side effect, akathisia, and not with a relapse of the schizophrenic illness.

(3) The first explanation suggested by Drs Barnes and Bridges, enhancement of the presynaptic release of dopamine, may explain the development of akathisia on high doses of antipsychotics rather than the recurrence of schizophrenia.

(4) As to the second explanation, anticholinergic toxic psychosis, the fact that in none of the three cases reported was there any mention of impairment of consciousness makes this explanation very unlikely.

(5) The development of restlessness, excitement, and aggression on high doses of antipsychotics is by no means a rare condition. We can recall at least two patients in the past six months in whom similar symptoms were