Amblyopia Due to Pheniprazine

SIR,—Noting with interest Mr. C. A. L. Palmer's report (January 5, p. 38) of four cases of toxic amblyopia during pheniprazine therapy, we would like to report a case seen here recently in which administration of this drug was associated with bilateral optic atrophy.

Our patient, now 50 years old, complained of headaches from 1954 onwards. He was investigated here as an out-patient in 1959, when an additional complaint of upper-limb paraesthesiae was diagnosed as due to cervical spondylosis and successfully treated. At that time, and on follow-up visits as late as February, 1960, his optic fundi appeared normal. His headaches were treated with several anti-migraine preparations. Early in 1960 he was diagnosed to be suffering from an endogenous depressive illness and he started on pheniprazine ("cavodil"). He continued on a daily dose of 9 mg. of this drug until December, 1962—approximately 30 months. He first noticed deterioration in his vision about September, 1961 (i.e., after some 15 months' treatment) and this steadily progressed. In February, 1962, he became aware of difficulty with colour vision particularly red/green discrimination. He was referred here at the end of November, 1962, when he was found to have bilateral optic atrophy, complete colour blindness,¹ and a small central visual field defect. Full neurological investigation (including air encephalography) failed to reveal any cause for optic atrophy. His headaches now rarely trouble him. Since stopping pheniprazine he has noticed no improvement, but no deterioration either, in his vision.

The special interest here lies in the development of an irreversible condition, optic atrophy in a patient known to have been treated over a long period with pheniprazine. Reporting on the use of this drug in hypertension, Gillespie *et al.*² noted the development of red/green colour blindness in six patients out of 21 being treated. The colour defect was apparently reversible on stopping the drug and the only funduscopic changes were those of hypertension. Subsequently Gillespie³ reported that three of these patients, on resumption of therapy, again developed impairment in red and green discrimination together with altered visual fields. Although two made a complete recovery, minimal optic atrophy remained in the third, recalling the toxic optic neuritis and atrophy reported on some occasions during isoniazid therapy (Sutton *et al.*,⁴ Keeping *et al.*,⁵ and Kass *et al.*⁶).

In Mr. Palmer's cases there appeared to be an inverse relationship between the length of time the drug was continued after the appearance of visual symptoms and the degree of improvement observed when the drug was stopped. This is in accord with our own case where the drug was continued about 15 months after visual upset was first noticed and the outstanding feature is optic atrophy.

Perhaps two conclusions can be drawn: (1) Symptoms developing late, as well as early, in the course of drug therapy should be regarded with suspicion. (2) Where a toxic effect is suspected the drug concerned should be withheld without delay.—We are, etc.,

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"Ancoloxin" and Foetal Abnormalities

SIR,—For several years I have been prescribing an association of meclozine and vitamin B₆ ("postadoxine" in Belgium, "ancoloxin" in England) to my patients suffering from vomiting of pregnancy.

I recently re-examined 587 files relating to deliveries I performed from January, 1961, to October, 1962. Out of these 587 cases, 195—that is, 33.2%—had received postadoxine in the course of pregnancy (150—that is, 25.5%—during the first three months). In this group of 150 I encountered two cases of malformations; in the group that received no postadoxine (392 cases) I observed four malformations.

	Total	Without Meclozine	With Meclozine†	
			During the First 3 Months	After the First 3 Months
Normal children ..	581	388	150	43
Malformed " ..	6	4	2	0

Although this study is only concerned with a limited number of cases, postadoxine does not appear to exert any teratogenic influence.—I am, etc.,

Liège, Belgium.

L. MARTIN-NAHON.

SIR,—No one would doubt Dr. G. I. Watson's obligation to issue an early warning to doctors of possible toxic effects of drugs (January 12, p. 122). The recent provisional reports, however, have undoubtedly caused anxiety to patients. I know of one colleague's wife who was in a better position than most to understand the inconclusive nature of the evidence, but who has been nevertheless afflicted by very considerable anxiety about her pregnancy. Pregnant women are, after all, in a very vulnerable emotional state.

A parallel situation has arisen with the recent reports of leg vein and coronary thrombosis in women using oral contraceptives. Such women are also unusually vulnerable to anxiety, for they include many with neurosis or marital difficulties.

In these days when everyone knows the name of "their tablets," and when the national press scrutinizes medical journals for news, surely we owe it to our patients to circulate *privately* any information which might alarm. And the more alarming such information, the greater is our obligation to maintain professional secrecy. Perhaps a newsletter distributed with *Prescribers' Journal* would serve the purpose.—I am, etc.,

Lyneham, Wilts.

I. N. L. JOHNSTON.

Treatment of Ménière's Disease

SIR,—Dr. William McKenzie (December 22, p. 1680) mentioned the vasodilatory action of intravenous histamine amongst the medical treatments of this condition. Thus administered, the effect is relatively transient owing to the rapid metabolism of the histamine.

We would like to point out that by using histamine ionization deposits of the substance are formed in the pores of the skin, whence it is absorbed slowly.^{1 2} Hence treatments at intervals of one week or longer give considerable relief of more lasting duration.

Clinical information and practical details of this method, which was carried out in the Histamine Clinic