I think that it is worth while drawing attention to the similarity of these two cases, thus amplifying the answer given by Dr. Pallis to the question about the frequency of sinus thrombosis in Behçet's syndrome.—I am, etc.,

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REFERENCES

- ¹ Masheter, H. C., *Proc. roy. Soc. Med.*, 1959, **52**, 1039.
- ² Cosgriff, S. W., Diefenbach, A. F., and Vogt, W., *Amer. J. Med.*, 1950, **9**, 752.

Diagnosis of Amphetamine Addiction

SIR,—Whilst agreeing with many of the comments expressed by Dr. P. G. M. G. Walker on the difficulties of the diagnosis of amphetamine addiction (6 February, p. 384), we cannot share his confidence in the value of the methyl-orange test (described by Connell in his monograph¹), as a possible solution to this problem. Over the past nine months we have carried out a routine estimation of urinary amphetamine by this method on all patients under 60 years on admission to this psychiatric unit. In 159 consecutive admissions amphetamine substances were reported in the urine in 82. An intensive investigation of drug administration, prior to admission, was then carried out in these cases, but ingestion of amphetamines was confirmed in only 12 cases. In the remaining 70 cases the positive test for urinary amphetamine was a non-specific reaction to a psychopharmacological or general medical drug—e.g., phenothiazines, amitriptyline, chlorthalidoxepoxide, ephedrine. Connell drew attention to this possibility (page 91), and recommended the use of a paper chromatographic method when this dilemma is encountered.

The widespread use of psychopharmacological drugs which produce false positives in the methyl-orange test now seriously limits its value as a routine screening procedure in the diagnosis of amphetamine dependence, as originally suggested by Connell. A more specific test for urinary amphetamine is required for clinical practice.

We hope to report our own experience of the methyl-orange test and the routine procedure in more detail, in the near future.—We are, etc.,

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REFERENCE

- ¹ Connell, P. H., *Amphetamine Psychosis*, Maudsley Monograph No. 5, 1958, Part 2.

SIR,—Of course Dr. P. G. M. G. Walker (6 February, p. 384) is right; since these patients are completely untrustworthy and inveterate liars the diagnosis of amphetamine addiction (like that of other addictions) rests upon demonstrating the drug in blood or urine. It is clearly as important to establish whether amphetamine is or is not the cause of a patient's symptoms as it is to determine, say, the protein-bound iodine in a patient whose symptoms could be due to hypo-

thyroidism. In the case of amphetamine detection this presents no difficulty to the well-equipped, well-staffed laboratory, though in some addictions—e.g., cocaine—the problems of detection are greater.

The difficulty Dr. Walker has experienced in getting investigations of his patients carried out are, therefore, not due to lack of methods but to the fact that facilities for executing any but the simplest of routine pathological investigations are just not available to the majority of psychiatrists and their patients. Laboratories in general hospitals are so undercapitalized, overworked, and understaffed as to be unable to undertake additional work for patients without apparent somatic disease.

Clinical pathology has until recently played comparatively little part in the diagnosis and treatment of patients with psychiatric illnesses, and has been used almost exclusively to detect coincidental "somatic" disease; which, every so often, turns out to be causal. There are, however, problems which arise in relation to the psychiatric patient—drug addiction, for example—which do not apply to the patient with somatic disease. With a greater understanding of the role of metabolic lesions in the causation of psychiatric disorders and the enlightened interest of psychiatrists in this aspect of their patients' illness the need for clinical, and particularly chemical, pathological facilities will increase, and, if experience in general hospitals is anything to go by, at an alarmingly rapid rate.

Our own experience is that over the past three years the number of requests to undertake investigations on patients suspected of drug-taking, causing psychiatric illness, has increased enormously, and that whereas it was formerly virtually confined to the detection of amphetamine it now extends over the whole field of addiction.

While illnesses due to drug addiction comprise only a small percentage of the patients referred to psychiatrists, the load on existing laboratory facilities is—as Dr. Walker remarks—already more than most can bear; I shudder to think what chaos will occur, when—as I am confident there will be—objective tests for the recognition and identification of the commoner psychiatric disorders become available. It is important that consideration is given to this matter by the relevant authorities now, and not to wait until the problem is actually upon us.—I am, etc.,

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VINCENT MARKS.

Hazards with Monoamine-oxidase Inhibitors

SIR,—A further danger of treatment with monoamine-oxidase inhibitors (M.A.O.I.) has come to our notice. We have recently seen two patients who have developed severe reactions after taking Procol while on M.A.O.I. drugs. This is a widely advertised preparation on direct sale to the public as a remedy for the common cold. It contains phenylpropanolamine hydrochloride 50 mg. and isopropamide iodide 2.5 mg. The former drug is a sympathomimetic amine with ephedrine-like effects and the latter is a long-acting anticholinergic.

The first patient was a 25-year-old female who had been on phenelzine 15 mg. three times a day for some months for depression. She developed nasal congestion and took one tablet of Procol, a drug she had used often, prior to taking phenelzine, without ill-effect. During that evening she had also eaten a portion of processed cheese, but this was her usual habit and had not caused any reaction on previous days. Within one hour of the ingestion of Procol she developed severe throbbing headache and vomiting. After another hour she became unconscious and went into status epilepticus, having at least nine major fits. Full consciousness was not recovered for about 12 hours. There was no previous, nor subsequent, history of epilepsy. She gradually recovered over a fortnight and a subsequent electroencephalogram was normal. Since this episode she has been on phenelzine again with no ill effects.

The second patient was a 48-year-old female taking mebenazine (Actomol) 5 mg. three times a day. She too had taken Procol in the past, before being on mebenazine, without ill effect. On this occasion, within two hours of taking one tablet of Procol, she developed severe frontal and occipital throbbing headache with vomiting. Bradycardia of 48 beats/min. was recorded by the general practitioner. The headache gradually disappeared over the next 48 hours. In both patients the blood-pressure shortly after admission was somewhat raised—being 150/100 mm./Hg in the first patient and 160/90 mm./Hg in the second.

It seems likely that the explanation of the symptoms of both patients is an encephalopathy following the combination of a M.A.O.I. and a sympathomimetic amine (phenylpropanolamine) contained in Procol. There are other tablets on sale to the public which contain phenylpropanolamine—for example, Mu-Cron, Eskornade, Dristan, and Capriton.

The M.A.O.I. drugs can be very dangerous when combined with certain other drugs and even some foodstuffs. We would again make a plea that all patients given these drugs should be strongly warned against taking any medication not first approved by their doctor.—We are, etc.,

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Combining the Antidepressant Drugs

SIR,—In this practice in 1959, 17 patients attempted suicide. Nine of these were provided with the means by us. Six were successful. Four patients died due to barbiturate overdosage. We referred 41 patients to psychiatrists, and 11 were admitted to hospital.

In this practice in 1964 three patients attempted suicide. We referred only four patients to psychiatrists, and three were admitted to mental hospitals.

Since 1960 we have prescribed no barbiturates. We have prescribed the antidepressant drugs more and more frequently as our confidence grew. In four years 11 attempts at suicide with massive overdosage of antidepressants have all ended in failure. Only three were admitted to hospital. Four cases have given us special cause for thought. One case on Tofranil (imipramine) and one case on Nardil (phenelzine) have developed jaundice. Both cases occurred when sporadic cases of infective jaundice were seen in the area. One case developed dependent oedema, and, in spite of stopping the Nardil (phenel-