TABLE 2

PRINCIPAL INDICATIONS FOR NEUROLEPTICS

Neuroleptic	*Principal indications*
Phenothiazines	Acute and chronic schizophrenia Hypomania and mania Acute toxic confusional states Disturbed behaviour in dementia and subnormality Medical and surgical disorders
Tetrabenazine	Control of orolingual-buccal dyskinesia due to prolonged phenothiazine medication
Thioxanthines	Anxiety states Schizophrenia
Butyrophenones	Schizophrenia Hypomania and mania
Pimozide	Schizophrenia
Oxypertine	Anxiety states Schizophrenia

DISCUSSION

Dr R. Steel

For how long should parenteral phenothiazine therapy continue?

Professor W. Linford-Rees

I think one should be prepared to carry on treatment for at least two years and in some patients for many years. Let us assume that the patient had been well for two years on these preparations, is free from symptoms and functioning well, at a certain stage one can try a gradual reduction in dosage to see if he still needs it. Some people will remain well without the drug, but others unfortunately will relapse and this requires further medication. With these patients one should probably carry on for a further two or three years. Really at this stage it is trial and error. There are no biochemical or other means which enable us to say which patient can be taken off treatment.

One must also consider some of the adverse reactions which may occur during prolonged treatment with these drugs. Severe depression is now well recognised as an adverse reaction. It can develop very suddenly, be very severe, and may sometimes carry a suicidal risk.

Although there are theoretical reasons why one should not give tricyclic antidepressants (because they both compete for the same binding sites), in practice I do not think this is all that important. I think it is necessary to give tricyclic antidepressants if the patient develops depression and electroconvulsive therapy if it is very severe. This shows the need for patients to be seen regularly and occasionally have their blood-pressure checked, because sometimes they can get cardiovascular adverse reactions as well.

Dr J. T. Hart

We are always being advised in treating any illness—not necessarily mental illness, to try to stick to a limited range of proven effective drugs. How on earth can we cope with this flood that you have just explained to us, remembering that the number of names can

be doubled because of both generic and brand titles, bearing in mind that the initial prescribing of these drugs does not lie with us. We usually get an ' order ' from a mental hospital with the most extraordinary lists of different pills which the patient is instructed to take every day.

Only a deranged person would be able to organise their day so that they could take all these. So we cheat and modify the drug régimes or we find out from the patient that he is not taking all the drugs anyway. I think I am probably speaking for a good many general practitioners when I say that we are barely able to keep our heads above water. Then Dr Parish tells us that we really must watch our prescribing in this field, this really is not a fair criticism.

Professor W. Linford-Rees

I greatly sympathise with you. I think all these new drugs are bewildering. It is almost a full-time job keeping up with all the new ones appearing. I think one needs to know a sedative phenothiazine like chlorpromazine (Largactil) and a stimulating one like trifluoperazine (Stelazine). Of the tricyclic antidepressants you must be familiar with a sedative one like amitriptyline because you can give that at night and help the patient to sleep. You want to know a stimulating one for depressed people, who need stimulating as well as their depression relieving and you need to know only one benzodiazepine—like diazepam.

Then, I think, of the new ones, you should get to know haloperidol perhaps, because of its value in hypomaniac and manic states. So I think, really, if you select which drugs you are going to familiarise yourselves with, then it is not quite such a big list.

Dr P. A. Parish

I do question some of our psychotropic drug prescribing during the past decade, notably our frequent use of hypnosedatives and minor tranquillisers for ill-defined conditions. As for understanding psychopharmacology in general practice, I only say " know a few drugs and know them well; know their indications and contra-indications, know their effects and side-effects, know their adverse reactions and interactions." I feel that the greatest contra-indication to the use of a drug is lack of knowledge of its toxic effects.

Do not be the last to give up an old remedy nor the first to start a new one. Get yourself familiar with an antidepressant that sedates—like amitriptyline or trimipramine and with an antidepressant that stimulates like imipramine. Know a phenothiazine that sedates like chlorpromazine and one that stimulates like trifluoperazine. Know one anxiolytic, e.g. diazepam. With these five or six drugs you should be able to treat most psychiatric disorders that you see. Do not be too influenced by your local psychiatrist if he tries everything that is new. Finally do not forget the placebo!