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## COMPLICATIONS OF BULIMIA NERVOSA

DEAR SIR,

The clinical features of bulimia, bulimia nervosa and binge eating are now well documented (Russell, 1979, Pyle *et al*, 1981, Abraham & Beumont, 1982, Fairburn & Cooper, 1984). Physical complications may be caused by binge eating, self induced vomiting, or purgative abuse (Fairburn, 1982). I report here, and comment on, two further complications of self induced vomiting.

Mrs A., a 31 year old housewife, was admitted to hospital with a 4-day history of haematemesis and melaena. She was treated conservatively, transfused with 4 units of whole blood and had no further bleeding. Barium meal examination showed normal oesophagus, stomach and duodenum. The attending doctors failed to elicit a history of longstanding weight preoccupation, dieting, binge eating, and self induced vomiting since the age of 17. She had induced vomiting many times a day in the week prior to presentation. Two years later, she re-presented elsewhere for management of her eating disorder.

Miss B., a 17 year old schoolgirl, was extensively investigated for vomiting accompanied by nausea and vague abdominal pain, after each meal. Barium meal and follow through examination revealed congenital malrotation of her bowel. This was confirmed at exploratory laparotomy, but was thought not to be responsible for the vomiting. Referal to a psychiatrist elicited a history of food and weight preoccupation, binge eating and consequent vomiting.

These two complications, upper gastrointestinal tract haemorrhage presumably due to a Mallory Weiss mucosal lesion (Foster *et al*, 1976), and illadvised surgical intervention, have not been reported previously. In neither case was sufficient enquiry made into patterns of eating. Mrs A., certainly, was anxious to reveal and seek help for her problem.

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## PRESCRIBING PSYCHOTROPIC DRUGS

DEAR SIR,

In their survey of prescribing patterns, Morgan and Gopalaswamy (*Journal*, March 1984, **144**, 298–302) criticise the value of drug surveys which fail to look at the patients' individual clinical details. Though this seems correct when a choice of drug or drug group is being criticised, I feel that there is still information to be learned from general surveys of prescribing. These serve to underline the need for rational pharmacotherapy, for instance, as set out by Ayd (1973).

This is illustrated by a review of patients' medication in the long-stay wards of a large psychiatric hospital, which I carried out without reference to individual diagnosis. There were 313 patients in these wards: 174 could be broadly classified as chronic psychogeriatric patients, and 134 as chronic psychotic. Their placements on these wards could be regarded as effectively permanent.

The findings as relevant to their discussion were as follows: 33% of patients were on more than three different drugs and 18% were on more than four. 55% of the patients were needing more than two drug rounds per day, and 21% were on four times daily medication. Most drugs can be given in a once or twice daily dosage.

In the chronic psychotic group, 84% were receiving neuroleptic medication. 37% were on two or more types at once, 11% on more than two, and 2% on four types. Only 8% of these patients received depot neuroleptics alone, and 25% received both depot and oral forms. There are few good reasons for chronic patients to be on more than one neuroleptic at once.

In the same group, 56% were receiving anticholinergic anti-parkinsonian agents, with 95% of

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these being on neuroleptics. McClelland *et al* (1974), showed that approximately all but 8% of this type of medication could be discontinued.

These findings point to where there are possible savings in the drug budget, and definite savings in the nursing time involved in long and frequent drug administration rounds. Knowledge of individual patients is not necessary for this survey to show the need for rational pharmacotherapy.

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## INJURIES IN A PSYCHIATRIC HOSPITAL

SIR,

The relationship between individual psychopathology and institutional life in chronic psychiatric inpatients has been a matter of much debate, as the behaviour may be regarded as a result of mental illness or as being promoted by the disturbed environment.

As an indicator of pathological aggressivity I considered injuries in the records of 130 chronic psychotics between January 1980 and May 1982. The patients were 33 females and 97 males with an average age of 59 years and periods of hospitalization from 15 to 30 years. There were 53 schizophrenics, 50 oligophrenics, 14 demented, 5 epileptics, 4 manic-depressives, 2 hypochondriacs, 1 general paresis and 1 morbus Fahr patients.

An injury, whether accidental, self produced or inflicted by another person, always constitutes an emerging signal of an altered psychological equilibrium. The following, according to the results of my research, are the main factors facilitating or inhibiting hetero or auto directed aggressivity:

| *Facilitating factors* | *Inhibiting factors* |
|---|---|
| 1. Crowding of the inpatients | 1. Functioning and cooperation of the nursing staff |
| 2. Seriousness of psychopathology of the patients | 2. Improvement of the patients' mental state |
| 3. Degree of restraint put upon the patients | 3. Increase of psychopharmacological therapy |

The chronicity of the institution, a typical psychiatric hospital, is shown by the fact that, during the period of time taken into consideration, factor no. 2 remained constant. A trial of psychiatric reform brought about a general decrease of factors 1 and 3.

As a result there was an increase of patients' injuries: the rate of injuries per month changed from 5.0 in 1980, to 5.9 in 1981 and 5.8 in 1982. The $\chi^2_c$, however, in the years 1980 and 1981, both for total patients d.f. = 1) and for male patients (d.f. = 1) is not significant (total patients $\chi^2_c$=2.35; male patients $\chi^2_c$=3.18).

Since the psychiatric hospital was at the time overrun by many and conflicting trends in the light of the psychiatric reform, the present data may partially support Sacerdoti's view (1971) that in an asylum (pathological) conflicts of the nursing staff are projected on to the patients, provoking an increase of aggressivity. Similarly it has indeed been demonstrated that the length of manic episodes correlated with the attitude of the nursing staff (Rizzoli, 1975). The salient factor seems to have been the diminished cooperation and friendliness of the nurses, which can be ascribed not only to the general worsening of medical assistance in Italy, but also to some conservative attitudes towards any serious effort of institutional reform. From this point of view the preventive measures suggested by Hawton and Leopoldt (1978) may represent a sort of *Verneinung* of the pathology of institutions.

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## HIGH-DOSE NEUROLEPTICS

DEAR SIR,

The paper by P. Bollini *et al* (*Journal*, January 1984, **144**, 25–27) on high dose neuroleptics is a sad document of the present situation of Italian psychiatry. Three deaths are of course no chance finding with a procedure which also produced 56% adverse reactions. The therapy as described should not only be abandoned but has to be condemned. One of the reasons for such practices is the shortage of psychiatric beds in Italy after the law disbanded mental hospitals.

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