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Correspondence

Letters for publication in the Correspondence columns should be addressed to:
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FATAL HEAT BLOCK AND CARDIAC ARREST FOLLOWING ECT

DEAR SIR,

In a case report of fatal heart block and cardiac arrest following ECT, Dr. M. O. A. Malik (*Journal*, January 1972, **120**, 69) stated 'it is considered important . . . to give atropine prior to treatment to reduce the stimulation of the vagus nerve by the shock'. In the instance reported, 0·65 mg. atropine was given subcutaneously an indeterminate time before the electric shock.

It should be stressed that a dose of 0·65 mg. atropine subcutaneously given (say) thirty minutes before ECT is inferior in vagal-blocking effect to a similar dose given intravenously immediately before the treatment (Bhattacharya and West, 1963). Intravenous administration of atropine in this manner has also been shown to be more convenient, and also more acceptable to the patient (Clement, 1962; Hargreaves, 1962). Moreover, it has been repeatedly stated (Lewis *et al.*, 1955; Arneson and Butler, 1961; Cropper and Hughes, 1964; Rubin, 1967) that the conventional doses of atropine given as premedication for modified ECT are insufficient, and that doses of the order of 1·5 to 2·0 mg. are necessary to prevent excessive stimulation of the vagus during this treatment.

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PREMENSTRUAL SYMPTOMS IN SELF-REFERRALS TO A SUICIDE PREVENTION SERVICE

DEAR SIR,

A recent interesting paper in this journal (Wetzel, McClure and Reich, Nov. 1971, **119**, 525) reported that women telephoning a suicide prevention centre who were in the menstrual or luteal phase of the menstrual cycle at the time of the call were significantly more likely to have prior premenstrual symptoms than women who called in the follicular phase. The authors suggested that this was at variance with the results which my colleagues and I had found (Tonks, Rack and Rose, 1968).

We reported a tendency for women who had premenstrual tension to fail to show the expected premenstrual excess of suicidal attempts. This tendency was only significant for parous women, not for women in general or those who had never been pregnant.

I do not think the findings disagree, because the studies are not strictly comparable. Wetzel *et al.* were studying a group who rang up threatening suicide, whereas we studied women who had made a suicidal attempt. These two populations, while overlapping, are very different. Those threatening suicide may differ from those making an attempt by as much as these latter differ from successful suicides (Stengel, 1964). Also our findings applied only to parous women, while their sample was not so limited.

The relationship between the premenstrual syndrome and the known premenstrual excess of female suicidal attempts is perhaps complex. Further research is needed to elucidate it.

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AN ADJURATION ON 'ADJUVANTS'

Dear Sir,

'Adjuvant'—forsooth! Now we know from the list of contents headings of your December issue that you really believe you edit the '*British Journal of Pharmaco-psychiatry*'! We, the 'adjuvant therapists', may be a motley crew of neurosurgeons, behaviour therapists, analysts and occupational therapists, but with only our scalpels, training schedules, couches and raffia we should be able to rescue most of our patients from the machinations of you druggists! Adjuvants of the world arise—we have nothing to lose but our humanity!

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[Point made.—Ed.]

CHLORPROMAZINE METABOLISM IN CHRONIC SCHIZOPHRENICS

Dear Sir,

The paper by Sved *et al.* (1) serves as a further reminder of the need for the monitoring of drugs used in psychiatry. We would however urge great caution in accepting the conclusions which the authors draw regarding resistance to chlorpromazine therapy. We fear a *non sequitur*.

It has already been suggested elsewhere (2) that absorption of unchanged chlorpromazine may be a significant factor in producing a satisfactory clinical response. In this case the presence of metabolites in the urine would be of little significance in judging the therapeutic status of any dosage regime.

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THE N.A.M.H. 'GUIDELINES'

Dear Sir,

The correspondence in the *Journal* on the topic of the N.A.M.H. 'Guidelines' makes me wonder whether the Joint Working Party would not perform its task in the most satisfactory way if it would supervise the making of a cartoon film showing how violent patients should be managed.

Staff have to be trained before they come to the wards and it would be a pity if only mental nurses were to be taught how to restrain a violent patient, because the two most aggressive patients I can remember were a drunk in a Casualty Department and a patient in epileptic furor in a medical ward of a General Hospital.

A twenty-minute film would be more instructive than a twenty-page guideline. Cartoons are better visual aids than actors in this field, not only because it is easier to emphasize the general principles of management but also because in the illustrations the steam can be taken out of rather traumatic situations.

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ERRATUM

We regret that there was an error in the paper, 'On the Arousal State-Dependent Recall of "Subconscious" Experience: Stateboundness' by R. Fischer and G. M. Landon, in the February issue (pp. 159–72). 'Satori' in Fig. 1 and in the second paragraph of the accompanying caption should read 'Zezen'.