
Correspondence

Disulfiram implantation

Sir: Shergill *et al* (*Psychiatric Bulletin*, October 1996, **20**, 624) raise an ethical question regarding the use of disulfiram implantation. In so doing they underplay the scientific evidence against this treatment.

They have correctly drawn attention to placebo controlled studies which show no efficacy for disulfiram implantation, but there is additional good evidence that therapeutic levels of disulfiram are not in fact achieved by the use of implants (Johnsen *et al*, 1990). Furthermore, even if therapeutic levels are achieved, the efficacy of disulfiram *per se* as a treatment for alcohol dependence is far from unequivocally established. Although it probably does have a role, we know little about how to choose the patients for whom it is most suitable (Hughes & Cook, 1997).

Turning to ethical issues, there is further cause for concern. If we think specifically of disulfiram implants, they would seem to fail (ethically) on all counts; they can do no good (they have no pharmacological action), they may do harm (e.g. wound complications), they transgress the principles both of autonomy (because the patient would not choose to have an inert treatment) and justice (because it is unjust to consume resources in an otiose endeavour).

What of the general question: can it ever be justified to use a form of treatment which is known to work only as a placebo? The ethical problem is then to do with truth-telling. It seems clear to us that telling a lie will always be to transgress a person's autonomy. We need also to consider the effects on the patient if and when the treatment does not work, which may include an increase in feelings of hopelessness, as well as the injury done to present and future relationships with doctors if the deceit is detected.

So for a variety of reasons, including a straightforward duty not to deceive patients, it would seem better to seek an alternative treatment to disulfiram implants.

HUGHES, J. C. & COOK, C. C. (1997) The efficacy of disulfiram: a review of outcome studies. *Addiction* (in press).

JOHNSEN, J., STOWELL, A., STENSRUD, T., *et al* (1990) A double-blind placebo controlled study of healthy volunteers given a subcutaneous disulfiram implantation. *Pharmacology and Toxicology*, **66**, 227–230.

J. C. HUGHES, *Radcliffe Infirmary, Oxford OX2 6HE*; C. C. H. COOK, *National Addiction Centre, Institute of Psychiatry, London SE5 8AF*

Chlormethiazole or chlordiazepoxide?

Sir: Duncan & Taylor's article (*Psychiatric Bulletin*, 1996, **20**, 599–601) highlights a curiosity in the British approach to the management of the alcohol dependency syndrome: the widespread use of chlormethiazole as an alternative to benzodiazepines. There are other aspects to this comparison that suggest preference for the latter.

Some alcohol dependent patients prefer chlormethiazole. Compared to chlordiazepoxide and diazepam, its short duration of action and its irritant properties give it an intoxication profile which more closely resembles the 'quick warm glow' of alcohol. This would explain its currency status among alcohol dependents, who may use it as an alcohol replacement while stocks last. Subjective intoxication with a long-acting benzodiazepine is a less familiar sensation. Although as far as I know, this difference has not been formally investigated, it is not unfamiliar to those balancing a choice of agents when starting detox. The withdrawing patient is sensitive to a wide range of cues, consequently the use of a less familiar substance might carry stronger connotations of change so important for successful outcome for treatment.

The longer duration of effect of chlordiazepoxide and its metabolites also lends itself to a smoother, more efficient detoxification. A leading North American authority on the management of alcohol dependency syndrome (Naranjo & Sellers, 1986) exploit this property to the full by using a 'leading dose' technique, giving the drug, at high dosage, in the first 48 hours only. This creates a more comfortable withdrawal with far lower total use of drug.

These advantages, combined with the poor safety margin for chlormethiazole, are surely grounds for abandoning its use altogether. Small surprise that in the same article, our North American colleagues observed of our use of chlormethiazole, that "its continued use is puzzling".

NARANJO, C. & SELLERS, E. (1986) Clinical assessment and pharmacotherapy of the alcohol dependency syndrome. In *Recent Developments in Alcoholism* (Volume 4), pp. 265–281. London: Plenum Press.

MARK SALTER, *Alcohol Problems Clinic, St Bartholomew's Hospital, London EC1A 7BE*