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(Accepted 15 May 1981)

SHORT REPORTS

Addiction to tranlycypromine

Psychiatrists recognise that patients taking tranlycypromine may develop psychological dependence and often have difficulty weaning them off even small doses of the drug. Some patients become addicted with a pronounced tendency to increase the dose. Neither Martindale¹ nor Goodman and Gilman² note the addictive properties of tranlycypromine. Since 1965 three cases of addiction have been reported.³⁻⁵ We describe four others.

Case reports

Case 1—A 33-year-old woman was admitted after prolonged abuse of Parstelin (tranlycypromine 10 mg, trifluoperazine 1 mg), culminating in an overdose of 40 tablets. Though initially lucid, 24 hours later she became hallucinated, confused, agitated, and aggressive. Over the next eight days she returned to normal. She had first suffered from depression at the age of 15, and had since had continuous psychiatric treatment. Personality disorder and depression were diagnosed. At the age of 25 Parstelin was started and before long she was taking 30 tablets daily. On at least two occasions she developed severe thrombocytopenic purpura due to the Parstelin abuse. All attempts at withdrawal from the drug were only temporarily successful.

Case 2—A 34-year-old schoolteacher was admitted complaining of addiction to Parstelin. He was taking 15 tablets daily, but had had some difficulty obtaining the drug, getting prescriptions from many different doctors. He had a history of three previous admissions for anxiety, depression, and alcoholism. On abstaining from Parstelin he suffered headaches, diarrhoea, and weakness and felt unable to cope with work. He also abused chlordiazepoxide, taking about 100 mg daily. While abusing Parstelin he did not drink alcohol. In hospital, on withdrawal, he complained of anxiety and depression. After discharge he immediately resumed Parstelin, taking up to 20 tablets daily.

Case 3—A 65-year-old man was admitted taking up to 30 Parstelin tablets daily. He had been taking Parstelin and chlordiazepoxide for 10 years and obtained prescriptions from many doctors. He stated that he felt well only when taking Parstelin. He had had treatment for alcoholism but since abusing Parstelin he had abstained from alcohol, stopped smoking, and worked effectively. After withdrawal from Parstelin and chlordiazepoxide he became tense, pacing around the ward all day. He was discharged drug free but soon resumed the Parstelin.

Case 4—A 39-year-old shopkeeper was admitted for depression and Parstelin abuse. He had obtained Parstelin and diazepam from numerous doctors and pharmacists. He took up to 20 Parstelin and 10 diazepam tablets daily, and without them felt unable to work. He was a shy, conscientious, obsessional man and had been a very heavy drinker. After admission and withdrawal from Parstelin he became restless and anxious and complained of generalised aches for 10 days, despite treatment with chlordiazepoxide and chlorpromazine. He showed no other withdrawal symptoms.

Comment

Addiction to tranlycypromine is not widely recognised and each of our patients received many prescriptions with relative ease. The addictive properties of tranlycypromine are not surprising in view of its close structural relation to amphetamine² and its powerful effect in suppressing rapid-eye-movement sleep.⁴ All our patients showed a notably increased tolerance to tranlycypromine and three also showed abuse and increased tolerance of benzodiazepines. On abrupt withdrawal of Parstelin our first patient became hallucinated

and confused. This was probably a withdrawal state, as in the case of Ben-Arie and George,³ but intoxication could not be completely ruled out.

We wish to emphasise that tranlycypromine should be used with great care in dependence-prone patients, and doctors should be wary of requests for prescriptions of the drug. Withdrawal from high dosage of tranlycypromine should be gradual because of the danger of withdrawal psychosis.

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(Accepted 6 May 1981)

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Damage to the tricuspid valve with a Swann-Ganz catheter

We report a case of damage to the tricuspid valve during preoperative insertion of a Swann-Ganz catheter. The lesion was discovered by visual inspection during the operation, which suggests that the incidence of undetected damage and its complications¹⁻³ might be greater than previously thought.

Case report

A 59-year-old woman with a history of rheumatic heart disease was admitted for elective aortic and mitral valve replacement and insertion of a tricuspid ring. Two months previously cardiac catheterisation had shown mixed mitral valve disease, predominantly stenosis and aortic insufficiency. The murmur of tricuspid incompetence could also be heard. Chest x-ray examination showed an enlarged left ventricle, right ventricle, and left atrium.

A pulmonary artery catheter was inserted for measurement of filling pressures and thermodilution cardiac outputs during the operation. A triple-lumen 7 FG flow-directed Swann-Ganz catheter (Instrumentation Laboratories) was inserted via the right cephalic vein in the antecubital fossa using a Cordis introducer. A cut-down had previously been performed on the right basilic vein, and the catheter was inserted at the right cephalic vein after failure to enter the chest using the left cephalic vein.

The catheter entered the chest easily, and as soon as it was in the superior vena cava the balloon was inflated and the pressure at the catheter tip