Correspondence

Letters to the Editor should not exceed 500 words.

Endomyocardial Thickening

SIR,—The interesting report by Dr. M. Black and Dr. J. M. Fowler (13 March, p. 682) is a useful reminder that the endocardium can sometimes become thickened and fibrotic in obscure cases of cardiac failure. It is a pity, therefore, that the patients were described as cases of "endomyocardial fibrosis," because this term, although it is anatomically correct, was originally given by workers at Kampala, Uganda, to a peculiar disease which had been found in Africans.[1] As more has become known about this disease it has been found to have reasonably consistent clinical, epidemiological, and morbid-anatomical characteristics.[2] It differs significantly from the two other diseases which occur in Africa, in both of which the endocardium may be thickened in patches—Becker's "cardiovascular collagenosis,"[3] and the "African cardiomyopathy" which has been reported from South Africa[4] and Southern Rhodesia,[5] and is commonly seen in Nigeria and other West African countries. Dr. Black and Dr. Fowler seem rather too ready to group together all cases of obscure heart disease with patchy thickening of the endocardium under the general title of endomyocardial fibrosis. Davies[6] showed that this could not be done.

Although the term "endomyocardial fibrosis" is merely descriptive and anatomical, it should be used with restraint: if it is not, extravagant ideas may be allowed to develop that endomyocardial fibrosis—as described originally at Kampala, and lately at Ibadan, Nigeria—has a "world-wide distribution." Dr. Black and Dr. Fowler are prepared to believe that this is so, but what evidence there is suggests that it is not.

Lest this letter might appear to be dominated by a semantic problem, I should like to suggest that a study of the geography of obscure forms of heart disease, and of endomyocardial fibrosis in particular, is very important in attempting to understand their aetiology. Although future work may possibly show that the endomyocardial fibrosis described from Uganda is not solely a tropical and a subtropical disease, it is remarkable that it is relatively common in the hot and wet regions of the Tropics, where it has been described often in spite of meagre medical services, and yet is exceedingly rare in other parts of the world where medical services are much more advanced. Just as a possible aetiology of Burkitt's tumour was suggested from a study of its distribution in Africa, so the agent which causes endomyocardial fibrosis may be revealed by studying the geographical distribution of this peculiar cardiac disease.—I am, etc.,

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Combining the Antidepressant Drugs

SIR,—Dr. William Sargant in his letter to you (23 January, p. 251) states that he believes "it is generally safe" to combine antidepressants like phenelzine (Nardil) and desipramine (Pertofran) "in proper dosages with great benefit to many patients." One recalls his previous letter on "Antidepressant Drugs and Liver Damage" (28 September, 1963, p. 806) in which he casts doubt on "the dangers supposed to arise from combining certain groups of" antidepressives, and the "supposed deaths from liver damage" attributed to iproniazid (Marsilid). Would he argue that there is no causal realtionship between lung cancer and smoking because not all those who smoke develop a bronchial carcinoma?

Recently in Perth, Western Australia, a woman aged 29, who had for some months been treated with phenelzine 15 mg. three times per day, was put on imipramine (Tofranil) 25 mg. by intramuscular injection three times per day. After the third dose she developed hyperpyrexia, a generalized rigidity, and became comatose. Antidepressants were withdrawn, and with treatment she recovered.[1] Fatal hyperpyrexia in the course of antidepressant therapy has been reported by L. W. Bowen,[2] and Stanley and Pal.[3] Professor Ayd mentioned several earlier and similar cases as long ago as 1961.[4]

There is evidence of the therapeutic value of these antidepressant drugs,[5] but it is essential also to know the risks entailed by their use in order to weigh these risks against the probable benefits. Accordingly we report that two deaths have occurred in Perth in patients given the usual therapeutic doses of amitriptyline (Tryptanol) who then took alcohol.[6] One of us (M. F. L.) undertook experiments to discover whether amitriptyline (0.017 mg./10 g. body weight) potentiates the effects of ethyl alcohol. Mice were used because they have to date given reliable prediction of interaction of drugs with ethyl alcohol in man. These experiments indicated that amitriptyline potentiates the effect of alcohol on the righting reflex (possibly increasing the hazard caused by those who "drive and drink") and that it greatly increases the mortality caused by large doses of alcohol. Several cases of adynamic ileus have been reported in association with amitriptyline therapy[7–10] as well as cases of urinary retention followed by death from ascending pyelonephritis with imipramine therapy,[11] precipitation of latent schizophrenia,[12] etc.

May we submit that the time has come for a critical reappraisal of antidepressive drug therapy? Perhaps such drugs should be reserved for the treatment of mild cases of depression, for there is much evidence that modified E.C.T. is still the best, the least time-consuming, and the most economical treatment for moderate-to-severe endogenous depressions.[13 14]

Surely combinations of antidepressant drugs are best avoided, and, in our view, the amitriptyline group should not be prescribed for elderly patients who may develop ileus. Patients should be advised not to take alcohol when on these drugs, pending further investigation.—We are, etc.,

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Vertebral-artery Thrombosis and Oral Contraceptives

SIR,—The success and the resultant popularity of oral contraceptives have been marred a little of late by the suspicion that the "pill," as it has come to be known, may occasionally be responsible for some undesirable side-effects. The most serious incidents, a number of which were reported lately,[1–5] are related to vascular thromboses to which women taking oral contraceptives may become liable for reasons adduced by Egeberg and Owren.[6] It is such an incident, which ended fatally, I wish to report.

A 26-year-old mother of two children, who always enjoyed good health in the past, had been taking Anovlar (4 mg. of norethisterone acetate and 0.05 mg. of ethinyloestradiol) for about six months. She was admitted as an emergency with a history of sudden onset of headache over the vertex, which was followed by pain in the right side of the neck, numbness in the right side of her face, and sensation of coldness in the right halves of her lips. She was subjectively giddy, and when trying to climb the stairs was ataxic. Then she fainted, and on coming round she had diplopia and hyperacusis in both ears. These two symptoms persisted and by the time she arrived in hospital she began to feel numbness and "pins and needles" in the left leg and arm.