Dr. E. J. Engberg, Supt.
Faribault State Hospital

DEPARTMENT OF PUBLIC WELFARE

TO: All Medical Services Division Institutions — Feb. 2, 1968
Attention: Medical Director

FROM: David J. Vail, M. D.
Medical Director

SUBJECT: Sudden Deaths of Patients on Phenothiazines

I thought you and the medical staffs would be interested in this letter from Dr. Burtrum Schiele to myself, dated January 23, 1968, in which he discusses the evaluation of sudden deaths of patients who are on Phenothiazines. Recent deaths of patients taking Mellaril led me to make an inquiry about this, addressed to Dr. Schiele.

DJV:rcj

UNIVERSITY OF *Minnesota*

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MEDICAL SCHOOL
DEPARTMENT OF PSYCHIATRY AND NEUROLOGY
MINNEAPOLIS, MINNESOTA 55455

January 23, 1968

David Vail, M.D., Medical Director
Department of Public Welfare
Centennial Office Building
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Dear Doctor Vail:

This is in answer to your letter of January 16 regarding the patient who died recently at [redacted] State Hospital. I would not be too quick to implicate the medications which she has been taking, as the record indicates that she had been regressing physically for the last two years. The dose of medication was within reasonable range. There is no general contraindication to a person with convulsive seizures receiving a phenothiazine agent. The record does not indicate whether or not the medication was of benefit, but we would more or less assume that it was.

Sudden and unexpected deaths occur from time to time in patients in mental hospitals as well as the normal population. There have been a number of articles, including the one to which you referred me, which speculate as to whether or not the long-continued use of psychotropic drugs leads to some type of subtle cardiac change which might increase the incidence of such deaths. These cases are uncommon. In many instances they are poorly documented; in others there is extensive pathology in the patient at autopsy, so that we really don't know whether or not there is a serious problem here. (from cardiac)

As far as I can tell, statistics from the various institutions do not show any increase in death rate since the introduction of tranquilizing drugs. It may be that some deaths are the result of the drugs and that these are counterbalanced by fewer suicides and fewer cases of exhaustion, etc.

Whenever I visit one of your state hospitals, I have made a special point of talking about the problems of maintenance therapy. Cumulative toxicities are definitely possible and I feel that the staff should periodically reappraise the need of continued neuroleptic medication. I'm sure that some patients receive drugs who no longer need them. Of course it is not an easy matter to find out who these patients are. As you know, the cumulative toxicity tends to fall under three headings:

a. Unexpected death, which is rare and iffy;
b. Chlorpromazine melanosis (skin-eye) problem, which is also rare. Here I feel definitely that a patient showing any part of this syndrome should not receive neuroleptic medications, especially chlorpromazine, if it is at all possible to avoid this.
c. The most troublesome cumulative toxicity is that of tardive dyskinesia. I think this is more troublesome because it afflicts a larger number of patients.

Again the issue is not entirely clear, but it seems increasingly apparent to me that older patients who have been on neuroleptic medications for many years are likely to develop persistent neurologic side effects, particularly perioral dyskinesia. The bad thing is that these do not subside readily when the neuroleptic drug is discontinued, and they do not respond to the antiparkinson agents.

I have a fourth issue which may not be very common, but from time to time at the University Hospital and elsewhere, I see a notation on the chart that so-and-so is sensitive to such-and-such a drug. Close examination frequently reveals nothing more than a spell of fainting (from Thorazine, for example) and people get careless when they see these red flags on the charts unnecessarily. Postural hypotension resulting in fainting is usually self limiting and benign. (Of course it wouldn't be in an elderly person or someone with a severe cardiac disease.) On the other hand, I think if a person has a really serious sensitivity to a drug, such as a blood dyscrasia or jaundice, we should put a red flag on the chart, saying that this patient should never have this drug again. If the rumors that I hear are correct, I know of a patient recently who had a severe blood dyscrasia, apparently induced by Thorazine, who recovered and several years later was given Thorazine again--recovered from that and the third time was given Thorazine (each time without knowledge of the previous experience) and expired. It should be possible to put some kind of a distinctive mark on the chart that would alert the personnel to this hazard--but such warnings should not be used in non-serious cases.

Problems like this continually arise, and since the personnel at the hospital change, new drugs are introduced, etc., I think it would be worthwhile if you could periodically set up some type of up-dating procedure for the staff at each of the various hospitals. As you know, I made a one-day visit to most of the state hospitals during the past two years, and I think this was of some benefit. You may have a better scheme in mind, but I would be very happy to be of service again if you wish me to and if I can find the time.

Sincerely,

Burtrum C. Schiele, M.D.

BCS:mm

P.S. The EKG changes induced by Mellaril are entirely benign as far as I can learn.