Trautner *et al.* (1957) used oral doses of barbiturate containing 12 to 23 per cent. bemegride, and found that up to a barbiturate intake of 750 mg. there was no effect on onset, depth or duration of sleep. The mixture acted exactly as the same amount of the barbiturate alone. At a barbiturate intake of between 1 and 1·5 grammes, however, the duration and depth of sleep were greatly reduced as compared with the effect of the same amount of barbiturate. At a barbiturate intake of between 1·5 and 3 grammes subjects either slept or were merely somnolent for a few hours.

Orwin *et al.* also fail to mention that there have been no fatalities reported with the combination tablets containing amylobarbitone 100 mg. and bemegride 10 mg. in each (Mylomide) since their introduction.

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REFERENCE

TRAUTNER, E. M., MURRAY, T., and NOACK, C. H. (1957). *Brit. med. J.*, *ii*, 1514-1518.

DEAR SIR,

We were familiar with the paper by Trautner *et al.* (1957) which is quoted by Dr. Neville, but did not see fit to take it into account in our study. Superficially, this work does suggest that bemegride is relatively more effective in larger doses, but Dr. Neville does not point out that the authors were studying the value of bemegrated barbiturate as a hypnotic in disturbed and chronic schizophrenic patients. The assessment of sedative effect was a subjective one in the control group, while in the patient group the criteria were clinical, namely, the dose required to render a disturbed patient tranquil and asleep. Our study used the objective evidence of the inflection point in the EEG graph, which in turn was matched with slurring when the patient was used as his own control.

The schizophrenic patients who comprised the major study had a 2–5 years' history and had been subjected to a variety of treatments, "several" having had continuous narcosis with barbiturates. None had responded to the ordinary doses of sedation, having had continuous narcosis with barbiturates. and the authors were searching for a method whereby they could prescribe even larger doses without the risk of severe poisoning.

Our criticisms of this work are:

(1) Many of the patients had had barbiturates over the years and in heavy doses with probable development of tolerance. This could have rendered them relatively more sensitive to the bemegride.

(2) The response of chronic and disturbed schizophrenic patients to barbiturates is notoriously difficult to assess. For example, a catatonic patient may respond to 0·5 grammes of intravenous barbiturate with remission of the psychotic features but little drowsiness. The authors did not demonstrate whether the sleep their patients enjoyed was due to the sedative effect of the barbiturate or to the amelioration of the psychotic process.

(3) Subjective tests and clinical observations are not as reliable as EEG studies. We tried to assess the duration of sedation on the patient's return to the ward, but had to abandon it because of the many variables involved, one being observer error.

(4) The authors used oral preparations, while we used the intravenous route. The latter does ensure that the drugs are in the blood stream, which we felt was important in a scientific study. It also eliminates the possibility of uneven absorption and produces a speed of reaction which is more readily observed, and the blood concentration of barbiturate approaches that of the toxic doses used by Trautner *et al.* (1957).

(5) The patient's mental state can influence the amount of barbiturate required to produce sedation, and with disturbed schizophrenics a constant baseline would be very difficult to obtain.

While Trautner *et al.* (1957) indicate that their selected patients were less drowsy with bemegride, we frankly do not know what conclusions can be drawn from this work. The absence of a report of suicide with bemegrated barbiturate is of interest, but must be correlated with the population at risk, which is probably small, and with the type of patient who has the drug prescribed, who may be addicted. The suggestion that the dose response curve does not run parallel throughout the range is an interesting one which still awaits proof.

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THE COUVADE SYNDROME

DEAR SIR,

Couvade, though recognized by the psychiatrist, is less well known to the general practitioner, who

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