FLUANXOL IN THE TREATMENT OF SCHIZOAFFECTIVE PSYCHOSES

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The schizoaffective psychoses consist of a group of psychic disturbances situated at half way between schizophrenias and major disorders of the state of mind. During the last decades many studies have been dedicated to them and the dominant idea is that they are of a heterogenous nature, as well as thet their therapy should be founded upon a sure diagnosis based on a longitudinal estimation of the patient, of the psychopathological phenomenology, and the autolytic risk as well (*Grecu*, 1975; *Angst, Felder, Lohmeyer*, 1979; *Brockington, Mendell, Wainwright*, 1980; *Goodnick, Meltzer*, 1984, *Predescu, Ciurezu*, 1985; *Marneros, Tsuang*, 1986; *Kielholz*, 1988; *Tuulio, Achte*, 1989).

Regarding the therapy with standard neuroleptics given daily in fractionated doses, we noted the presence of certain difficulties both for the patients and their families. On the contrary, the retard neuroleptic given intramuscularly for approximately 30 days has supplied large perspectives for therapeutical rehabilitating actions by the increase of compliance and accept of the prescribed treatment.

Fluanxol is an esterified substance with fatty acids and a carbon atom in its molecule, a fact that grants its liposolubility and its injectability as well. The liposolubility of the Fluanxol-fatty acid complex facilitates to carry out certain constant levels of plasmatic concentrations of active substance which are higher than when given orally. This phenomenon is determined by the fact that the hepatic transit and hepatic inactivation are avoided when Fluanxol is injected. Among the clinical-therapeutical advantages we mention: the antipsychotic action is approximately equal to that of the standard product given in adequate doses; reduction of the toxicity risk and of the severe secondary phenomena; therapy is more easily and simply carried out; the improvement of the patient-doctor relationships and with the family as well; reduction of relapses, time and posological savings, etc.

Material and Method

The present paper is based on the clinical-therapeutical observations performed on 130 patients hospitalized during 1970-1993 in the Psychiatric Clinic of Târgu-Mureş for psychic disorders of the mixtural type (schizo-affective, with or without interpretative elements) and who benefited of a treatment with Fluanxol retard.

The selection of the patients of the both sexes was made on diagnosis criteria, but also considering certain demographic parameters, too. The patients that were admitted received Fluanxol under hospitalization conditions, after a period of 14 days in which they received orally the standard neuroleptic, and which was a " tolerance test", too.

When Fluanxol retard began to be given in doses of 20-40 mg., at intervals of approximately 30 days, the standard neuroleptics were retired. Fluanxol was administered for a period of 6-12 months and during the first days of treatment the patients also received reduced doses of anti-parkinsonics.

According to the somato-psychopathological phenomenology, Fluanxol was associated with other drugs such as: antidepressors, antiparkinsonics, cardiovascular analeptics, vitamins, barbiturics, and the like, while for the suicidal risks a few sessions of electroconvulsiotherapy were administered.

Results and Discussion

The studied group consisted of 130 patients between: 19 and 49 years old, out of which 57% were females and 43% males (Fig.1). As regards their marital status the predominance of "married" is noted with 61%, followed in decreasing order by "unmarried" with 15%, the "divorced"' with 13%, and those with nonofficial marital relationships (the"concubines") with 7%. and the widows with 4%. As regards the age decades in which the schizoaffective psychoses occurred we got the following data:

- in the second decade (10-19 years) = 10%
- in the third decade (20-29 years) = 41%
- in the fourth decade (30-39 years) = 36%
- in the fifth decade (40-49 years) = 13%.

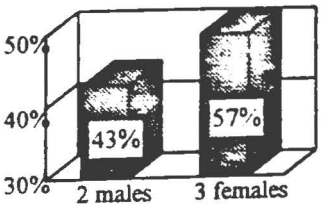

Fig. 1.: The distribution on sexes

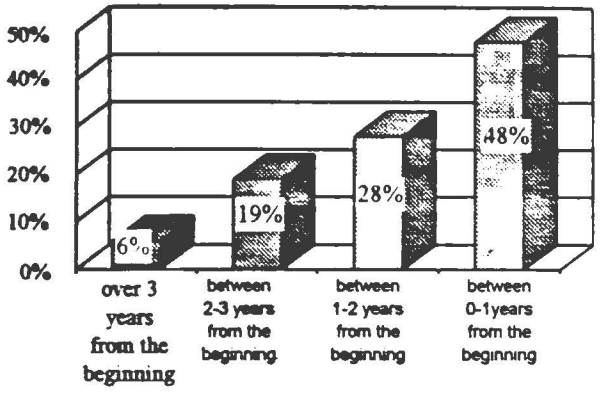

Fig.2.: The distribution of the patients according to the oldness of the disorder and beginning of the therapy

As for the patients' distribution according to their seniority in disease and diagnosis we established that in 47% of the cases therapy was started between 0-1 year from the onset, in 28% between 1-2 years, in 19% between 2-3 years and in 6% after more than 3 years from the onset of the psychosis (Fig. 2).

The tabulated data showed a significant prevalence of the females as compared to males, as well as a concentration of the both onset and start of therapy with Fluanxol in the III-rd and IV-th decades of age (77%), and a high percentage (75%) of the patients having a seniority between 0 and 2 years from the onset to the start of the therapy.

The analysis of the data regarding the socio-professional status of the patients reveals that 30% of them were workers and farmers, 20% were pensioners, 18% without jobs, 13% housewives and 10% pupils and students. The *longitudinal* study and the analysis of personal antecendents showed that 62% of the patients had manifested previously to illness certain schizo-affective and interpretative features. Concomitantly with the onset 53% of them lived anxiously, depressively or, from an interpretative point of wiew, they manifestied depersonalization, derealization, blurring or dimming of reality in the form of an "existential deadlock" or a "personal desintegratory catastrophy". In 41% of the patients paranoid ideas were present and in 28% there were suicidal concerns. Sexual desires were manifested by wish and repulsion, frigidity, shyness, fear and tendencies for perversion, but more rarely for zoophily, all these exiting in 1% of them.

The oeredocollateral antecedents evidenced the presence of schizoparanoid and state of mind disorders in 42% of the close relatives and alcohol and drug excesses in 16%, while in 42% of the patients there was no evidence of the presence of family vulnerability. As regards their familial situation when the patient was taken into study, we pointed out the fact that many of them came from disorganized families (54%), showing affective-educational defficiences and having difficulties in communicating with partners and children.

The schizoaffective psychoses are constituted of a dissociating-interpretative and depressive-maniacal mixtural symptomatology. The intensity or predominance of these symptoms may change from one moment to the other, and for this reason their estimation and clinical diagnosis, as well as the estabilishment of a therapeutic plan require much attention and professional competence. In 56% of our patients, the disorders of the state of mind that had settled during the onset period of the dissociating phenomenology were more or less evident or screened from the affective ones, in 25% they started during the schizophrenic state, and 19% during the post-psychotic period after the therapy with standard neurolentics for a few weeks or months, and, very seldom, even with Fluanxol.

In 26% of the patients, the depressive symptoms were prevalent and screening the discordant syndrome, while the rest of 74% of them presented a psychopathologic picture that consisted of mixturalschizo-affective and interpretative symptomatology the predominance of which could change from one day to the other.

In the patients who had the schizoaffective onset by the means of depressive phenomenology, the administering of antidepressives contributed to a more significant evidence of the dissociating phenomena which had been previously screened by the depressive syndrome, thus even the antidepressors could help to estabilish a precise diagnosis. In the patients in whom the depressions settled against a schizophrenia with known antecedents or at the closing of the attack or after a certain time from it, the diagnosis estabilishment did not present any difficulty.

Taking into account the above said, we could evidence the important role played by a correct anamnestic investigation for both a precise and correct diagnosis and the setting up of an adequate treatment. As a first remark we should like to point out the fact that only 29% of the patients treated with Fluanxol retard presented an unfavourable evolution, being necessary to change therapeutical conduct by renouncing to administer the drug. In 41% of the patients the remission was characterized by a gradual dissipation of the schizo-affective and interpretative phenomenology and presenting further pseudo-neurotic accuses, while the rest of 30% showed a good enough improvement, but with the persistence of isolated phenomena of

the hyperpublic type internal and relational discomfort with a diminished spontaneity and initiative.

The therapeutic efficiency (superior to that of the standard preparations or even of other retard neuroleptics) is expressed by the socio-professional reinsertion of the treated patients and especially when it is given during more months associated with some other adequate medicine (antidepressives, antiparkinsonics, vitamins, etc.).

The best results were obtained with the patients that had a diagnosis and a treatment during the first months after the onset or relapses (Fig.3.).

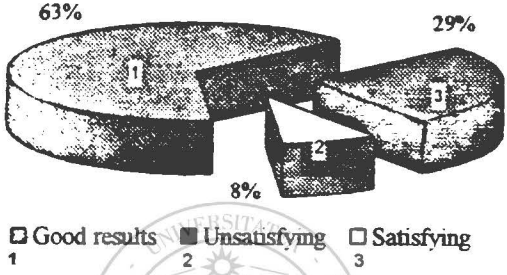

Fig.3.: Therapeutic efficiency

Good results were obtained in 63% of the patients, satisfactory in 8% and unsatisfactory in 29%, all these demonstrate that Fluanxol retard when given associated with other adequate preparations, has a good therapeutic value in schizo-affective psychoses.

Our observations show the fact that Fluanxol retard has also certain depressive and anxiolytic potencies, without excluding the possibility of its intervention in the depressogenous mechanism, especially after a long duration treatment, these depressions being dimmed in a short time after its association with antidepressors.

Generally, we have succeeded in reducing the dimension of both acute episodes and their recurrences, improving them alongside with the consolidation of their connection with reality. In this respect, the patients were offered various strengthening programs in accordance with the occurrence of the improvements, helping thus their easier reinsertion in the daily circumstances of the socio-professional existence, as well as to help them to enstrange themselves from the social vacuum they lived in during the psychotic episode. The terapeutic efficiency of Fluanxol retard is manifested by the reduction of the psychotic phenomenology of the schizo-depressive type alongside the improvement of their relationship with the sorrounding environment. It is to be noted that in high doses (80 mg and more). Fluanxol may have in some cases depressogenous effects while in low doses (20-40 mg)

it has depressolytic effects. An individualization of the doses was made to reduce or remove both the psychotic and indesirable (secondary) phenomena. As it is known that the undesirable phenomena are more frequent and more intense in the patients with organic and cerebral lesions, we avoided to give this drug in such cases and in first months of pregnancy as well. Local tolerance was excellent, no phenomena of induration was noted and neither of the other type during the treatment thet extended between six months and two years.

The secondary effects of Fluanxol, although they are approximately identical with those induced by standard neuroleptics, are much reduced and can be eliminated easily by associating this drug with antiparkinsonics or other adequate preparations. These phenomena, which are more frequently of the asthenic type, occur between the second and the seventh day of giving Fluanxol. Some of the patients presented the following secondary disorders:

16% - slight tremblings of the extremities, reversible in antiparkinsonics;

9% - arterial hypotension with dizziness and balance disorders;

6% - moderate phenomena of hypertonus-hypokinetics that are dimmed by antiparkinsonics;

3% - tasikinesis and akatisis.

Usually, these phenomena are frequently encountered in aged patients, in those with cerebral lesions, and in the case of giving high doses of narcoleptics.

The absence of certain severe undesirable phenomena demonstrate that Fluanxol retard is easily handled and its secondary effects are of a lower intensity and more rarely encountered than in the case of standard neuroleptics.

Conclussion

In a part of the patients the dissipation of the psychopathological phenomena is not concluded by the stay in hospital, on the contrary, these phenomena persisted for some months by a residual symptomatology that required both hospitalization and carrying on the treatment as out-patients, as well as the prolongation of the periods of work incapacity. Almost 38% of the studied patients for 6-7 months present subclinical-psychotic and psychopathological residual phenomena.

The combination of the retard neuroleptic with lithium preparations is efficient in many cases, especially in notypical maniacal psychoses or in those with adiploral dissociating nuance.

In the cases of schizophrenias, combining the retard neuroleptics with anticholinergic antidepressors contributed to both the improvement of the patients' state and the diminishing of the adverse phenomena (extrapyramidals)

It is very important to inform both the patients and their families about the good prognosis for the development of the schizoaffective disorder even if during the episode the psychopathological phenomenology is frightening.

Retard Fluanxol's efficiency in the therapy of the schizoaffective disorders is much more evident in the patients to whom besides the drug's administration there were involved other therapeutic activities (occupational and sociotherapeutical), too.

Narcoleptic therapy of the schizophrenics has changed the prognostic of the disease, evidencing that its development course does not implicitly advance towards deterioration and chronicization.

Fluanxol retard has demonstrated its therapeutical efficiency in the schizo-affective psychoses, 63% of the treated patients succeeded to resume their socio-familial and professional relationships.

Good and very good results were obtained in the patients to whom both the diagnosis and the treatment were applied during the first months after the onset of the disease.

Our observations indicate that Fluanxol has also good effects upon the depressive-anxious states with psychotic-dissociating elements acting on them by dissipating the dysthymic and anxious psychotic phenomena contributing to normothymization, but in spite of all these it cannot be classified among the anticholinergic antidepressors.

When Fluanxol retard is injected intramusculary once at 3-4 weeks, its absorbtion is made straight into the systematic circulation (maintaining a medium concentration for 2-4 weeks).

In this way, the interposition of the liver is avoided where a part of the standard neuroleptic is metabolised (when it is given orally) and this determines the fact that the doses are too high without an increase in the efficiency of the therapy, on the contrary it stresses the occurrence and intensity of the undesirable phenomena.

The undesired effects induced by Fluanxol retard are much more diminished and milder as compared to those induced by standard neuroleptics or even by other retard neuroleptics.

Fluanxol retard given in lower doses (as compared with standard preparations) induces in the patient a state of relief in carrying out interpersonal contacts and communications, stimulating initiative which open the possibility to involve various psychotherapeutical methods.

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