The

International Society For Twin Studies

announces the

SECOND INTERNATIONAL CONGRESS ON TWIN STUDIES

to be held in Washington, D.C., USA
29 August–1 September 1977

The International Society for Twin Studies was established by the General Assembly of the First International Congress on Twin Studies (Rome: 28 October–2 November 1974) with the purpose of furthering research and social action in all fields related to twin studies, for the mutual benefit of twins and their families, and of scientific research.

The Society is governed by a Board presently consisting of the following officers:
President: L. Gedda (Italy);
Vice-Presidents: G. Allen (USA), J. A. Böök (Sweden), J. Maxey (USA), H. Mitsuda (Japan), R. Zazzo (France);
Secretary General: P. Parisi (Italy);
Chairman of the Membership Committee: M. Feinleib (USA);
Chairman of the Constitutional Committee: M. Milani-Comparetti (Italy);
Chairman of the Committee for Working Groups: L. Keith (USA).

Acta Geneticae Medicae et Gemellologiae, the international quarterly devoted since 1952 to human genetics and twin studies as applied to the various fields of biomedical and psychological research, is now the official organ of the Society.

cut here

Dr Gordon Allen
Chairman, Organizing Committee
Second International Congress on Twin Studies
Clinical Centre, 2N252, National Institutes of Health
Bethesda, Maryland 20014, USA

Dear Dr Allen:

☐ I plan to attend the Congress. Please send further information.

☐ I hope to present a paper. (Subject, if determined: .....
.....).

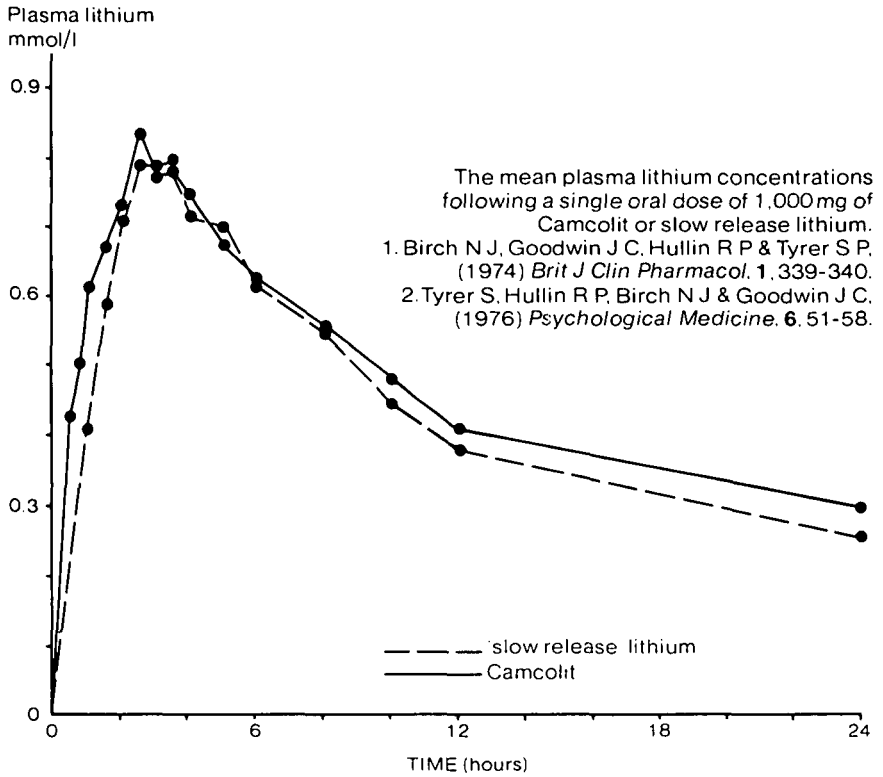
☐ I may attend the Congress but my plans are not definite at present. Please send further information.

☐ I should like to apply for membership in the International Society for Twin Studies. Please direct my request to the Membership Committee.

☐ I should like to subscribe to the International Quarterly of Medical Genetics and Twin Studies, Acta Geneticae Medicae et Gemellologiae, official organ of the Society (Society members or fellows: US $30, nonmembers; US $35). Please direct my request to the Journal.

My name and address: .....
.....
.....

See how conventional and slow release lithium compare



The mean plasma lithium concentrations following a single oral dose of 1,000 mg of Camcolit or slow release lithium.
1. Birch N J, Goodwin J C, Hullin R P & Tyrer S P, (1974) *Brit J Clin Pharmacol*, **1**, 339-340.
2. Tyrer S, Hullin R P, Birch N J & Goodwin J C, (1976) *Psychological Medicine*, **6**, 51-58.

The authors of two recent comparisons[1,2] between Camcolit and the two types of slow release lithium concluded that there is no therapeutic basis for the administration of slow release lithium preparations in preference to Camcolit.

As their studies show, there is no significant difference in the rate of absorption or excretion of the two types, despite the disparity in their rates of release in vitro.

The authors do state, however,[2] that there are sound economic grounds for preferring Camcolit.

In fact, slow release lithium costs almost three times as much—so in the treatment and prophylaxis of mania, manic-depressive illness and recurrent depression, Camcolit offers maximum therapeutic effect at minimum cost.

Camcolit is supplied in tablets of lithium carbonate BP 250 mg to allow full flexibility of dosage. Packed in securitainers of 100 and 1000.

Camcolit

Equal effect - at almost one-third of the cost

Further information on request from:
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Anafranil® in depression

"The most striking finding however, was the number of patients who showed spectacular improvement and who had been ill for considerable periods of time. By and large this group were of a chronic grumbling type who sought much and constant medical attention and yet did not reward the doctor by getting better."

Clomipramine (Anafranil) in the treatment of chronic intractable depression.
Paper read at the Fifth World Congress of Psychiatry, Mexico D.F. 1971.

"The difference between the proportion of patients in hospital who improved when treated with electroconvulsive therapy, conventional antidepressant drug therapy and intravenous infusion of clomipramine was statistically significant in favour of the last mentioned treatment. Patients on clomipramine as a group needed fewer treatments and returned to work more rapidly than did their counterparts having electroconvulsive therapy."

A new adjunct to the treatment and management of depression : intravenous infusion of clomipramine (Anafranil). S. Afr. med. J., ***45,*** *168 (1971)*

"72% (of 57 patients) showed a very good or good response and 96% made some improvement. This compares very favourably with the response of similar groups of severely depressed patients to E.C.T., and it is postulated that intravenous chlorimipramine can be offered as an alternative form of treatment."

"Oral group : 78 per cent showed a very good or good response and 96 per cent improved to some extent. This also compared favourably with the results obtained with other antidepressant drugs in similar groups of patients."

Parenteral and oral chlorimipramine treatment of depressive states. Brit. J. Psychiat., 122, 189 (1973)

Anafranil® in obsessional/phobic disorders

"Clomipramine has the two distinct properties of being an anti-depressive and an anti-obsessional drug."

Clomipramine (Anafranil) in the treatment of obsessional states : A psychiatrists view. J. Int. Med. Res., ***3*** *(Supp 1) 83 (1975)*

"Obsessional illnesses have always been notorious for their resistance to treatment and phobic states, especially, when they are diffuse and polysymptomatic, do not respond always to deconditioning or flooding techniques . . . . A treatment which offers brevity with a 70% chance of disappearance or considerable reduction in symptoms is worth offering to patients as a first choice of therapies."

Clomipramine (Anafranil) in the treatment of obsessional illnesses and phobic anxiety states. J. Int. Med. Res., ***1,*** *403 (1973)*

"It is our view that clomipramine not only gives good results in severe and moderate depressive states, but it is emerging as the treatment of choice in obsessive compulsive disorders and phobic states."

Letter, Treating phobias. World Medicine, ***7.*** *11: 15 (1972)*

"The mode of action of Anafranil is unknown but without doubt it appears to exert a beneficial effect on neurotic responses in general and phobic and obsessional states in particular."

An investigation into the use of Anafranil in phobic and obsessional disorders. Scot. med. J., ***20*** *(Supp), 61 (1975)*

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Indications

Tryptizol' is recommended in the treatment of depression including that accompanied by anxiety.

Tryptizol' may be used successfully in depression that is a manifestation of psychosis or neurosis, whether endogenous or reactive in nature. Endogenous depression is more likely to be alleviated than are other depressive states.

Tryptizol' has an anxiety-reducing and sedative component to its action which is particularly helpful in alleviating anxiety or agitation that often accompanies depression.

It has been used with benefit in depressions of long or short duration, and with a wide range of intensity. As with other psychotherapeutic agents, all patients do not respond to the same degree. Some patients respond promptly, while others may require up to 30 days to obtain benefit. Lack of response may occur occasionally.

Depressive reactions and associated anxiety accompanying chronic illness may be relieved by 'Tryptizol'.

Dosage and administration

Start with one 75 mg capsule at bedtime and increase, if necessary, to two capsules at bedtime or one in the morning and one at night. The 75 mg capsule may also be used as maintenance therapy.

The anxiety-reducing and sedative effect is usually rapidly apparent. The antidepressant activity may be seen within 3 or 4 days or may take up to 30 days to develop adequately.

Contra-indications

Hypersensitivity to amitriptyline, concomitant use with a monoamine oxidase inhibitor (see 'Precautions'), during the acute recovery phase following myocardial infarction. See 'Usage in Pregnancy' under 'Precautions'.

Precautions

Combined use of antidepressants having varying modes of activity requires thorough knowledge of pharmacology of all agents. Allow minimum of 14 days to elapse following discontinuation of MAO inhibitors and introduction of Tryptizol'. (Hyperpyretic crises, severe convulsions and deaths have occurred when tricyclic antidepressants and MAOI drugs were given simultaneously.) Introduce 'Tryptizol' cautiously and gradually increase until optimum response is achieved.

When amitriptyline is used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated. If used in manic-depressive psychosis a shift towards the manic phase may occur. Paranoid delusions, with or without associated hostility may be exaggerated. (In such circumstances either reduce dose of amitriptyline or add major tranquillising drug.)

The possibility of suicide in depressed patients remains during treatment and until significant remission occurs. This type of patient should not have easy access to large quantities of the drug.

Concurrent administration of amitriptyline and electroconvulsive therapy may increase the hazards of therapy and therefore should be limited to patients for whom it is essential.

Use with caution in patients with history of seizures, urinary retention, or increased intra-ocular pressure. With narrow-angle glaucoma, even average doses may precipitate an attack. Closely supervise treatment in hyperthyroid patients, those receiving thyroid medication, anticholinergic or sympathomimetic drugs, including adrenaline combined with local anaesthetics (careful adjustments of dosage are required) and those who receive large doses of ethchlorvynol concurrently.

It may enhance the response to alcohol and the effects of barbiturates or other CNS depressants. Alertness may be impaired in some patients (activities made hazardous by this diminished alertness should be avoided).

Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressant drugs have been reported to produce arrhythmias, sinus tachycardia, and prolongation of the conduction time, myocardial infarction and stroke.

Amitriptyline may block the antihypertensive action of guanethidine or similarly acting compounds.

Discontinue amitriptyline several days before elective surgery, if possible.

Both elevation and lowering of blood sugar levels have been reported.

Not recommended for depressed patients under 12 years of age.

Safe use during pregnancy has not been established. Weigh benefits against possible hazards to mother and child when administered to pregnant or possibly pregnant women and to nursing mothers.

Side effects

Note: Included in the listing which follows are a few adverse reactions which have not been reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

CNS and neuromuscular: Confusional states, disturbed concentration, disorientation, delusions, hallucinations, excitement, anxiety, restlessness, *insomnia, nightmares, numbness, tingling, and paraesthesiae of the extremities*, peripheral neuropathy, incoordination, ataxia, tremors, seizures, alteration of EEG patterns, extrapyramidal symptoms, tinnitus.

Anticholinergic: Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitisation, oedema of face and tongue.

Haematological: Bone-marrow depression including agranulocytosis, leucopenia, eosinophilia, purpura, thrombocytopenia.

Gastro-intestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhoea, parotid swelling, black tongue, rarely hepatitis (including altered liver function and jaundice).

Endocrine: Testicular swelling and gynaecomastia in the male, breast enlargement and galactorrhoea in the female, increased or decreased libido, elevation or lowering of blood sugar levels.

Other: Dizziness, weakness, fatigue, headache, weight loss or gain, increased perspiration, urinary frequency, mydriasis, drowsiness, alopecia.

Withdrawal symptoms: Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

Presentation

Tryptizol' 75, slow-release capsules marked 'MSD 649' containing 75 mg amitriptyline hydrochloride BP as a pelleted formulation in bottles of 100.
Product licence number: 0025/0116.

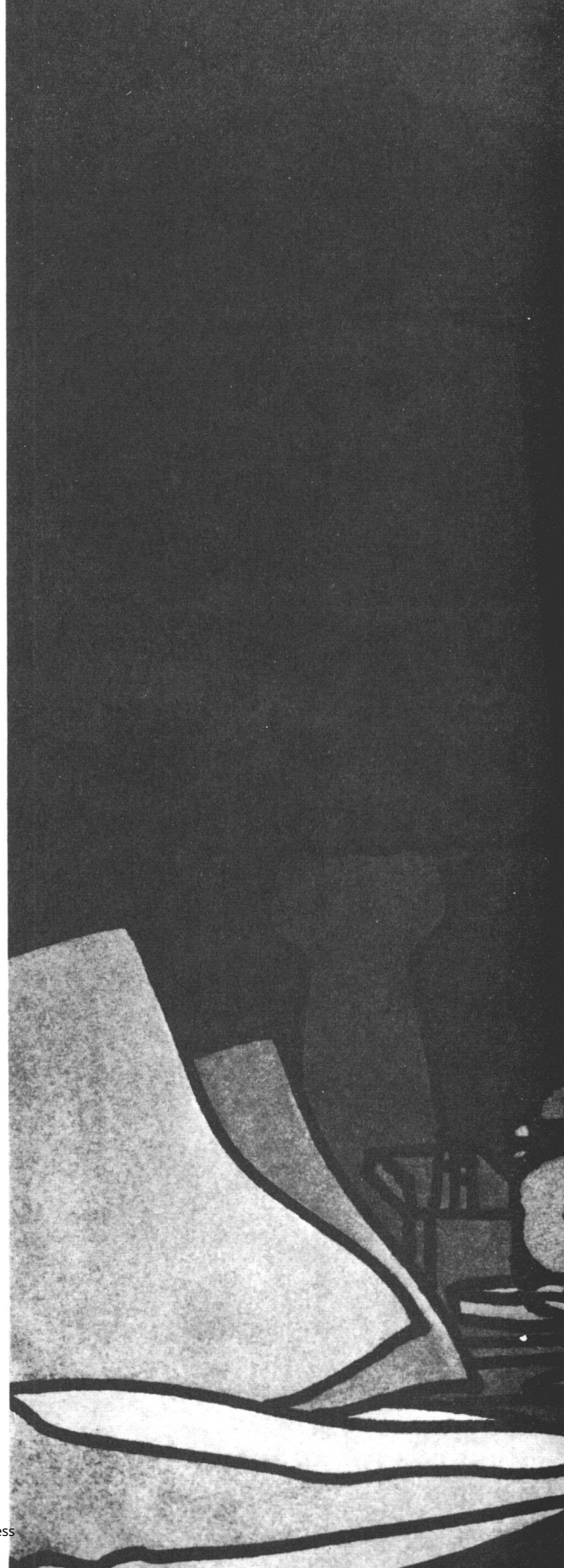
Detailed information is available to physicians on request. ® denotes registered trademark.

Tryptizol® 75
once-a-day

MSD

Merck Sharp & Dohme Limited
Hoddesdon, Hertfordshire, EN11 9BU

76-4066



Tryptizol® 75 once-a-day treats depressive insomnia.

When depression causes sleep disturbances, 'Tryptizol' 75 can help ensure a good night's sleep. 'Tryptizol' 75 is usually taken as a single dose at bedtime.

'Tryptizol' 75 offers a single, convenient daily dose with less need to prescribe hypnotics.

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NOTES FOR CONTRIBUTORS

PAPERS Papers for publication should be addressed to the Editor, Professor Michael Shepherd, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF. Contributors should send at least two copies of the text, tables, and figures. Copies other than the first may be xeroxed. The S.I. system should be adopted for text and figures. A short summary of about 50 words should be provided at the beginning of each article. Foreign quotations and phrases should be followed by a translation. Submission of a paper will be held to imply that it contains original work that has not been previously published and that it is not being submitted for publication elsewhere.

In addition to longer articles, the Editor is prepared to accept preliminary communications of up to about 1,500 words.

Manuscripts must be typewritten on one side of the paper in double-spacing with wide margins. The following information must be given on a single separate sheet: (1) title and short title for running head (not more than 100 characters); (2) authors' names, and (3) department in which work was done. Footnotes on the same sheet should list: (i) the authors' present addresses if different from departments in which work was done; (ii) name and address of the author to whom correspondence should be addressed; (iii) receipt of grants. Authors who would like a reprint address to be printed should include this on their manuscript.

REFERENCES (1) In the text these should follow the Harvard system – that is, name followed by date: Brown (1970). If there are more than two authors the first author's name followed by *et al.* should be used, even the first time that the reference appears. (2) The list of references should be typed in alphabetical order on a separate sheet and should appear as follows: Brown, J., Williams, E. & Wright, H. (1970). Treatment of heroin addiction. *Psychological Medicine* **1**, 134–136. Journal titles should be given in full.

Books should be cited as follows: Brown, J. (1970). *Psychiatric Research.* Smith: Glasgow.

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