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Correspondence

THE GRÜNTHAL-STÖRRING CASE OF AMNESIC SYNDROME

DEAR SIR,

In his discussion of this famed case B., Talland (1965) wrote that probably the last interpretation of this case had not yet been published. He was right, as the most competent analysis and interpretation given by Professor Zangwill in the *Journal* for February 1967 proves. Some brief remarks on Zangwill's paper may have some significance. The patient's attitude and responses, described in the reports published by Scheller and by Völkel and Stolze, are somewhat reminiscent of those of the patients described by this writer in 1956. My observations concerned patients involved in the process of claiming disability pensions to avoid being prisoners or being involved in criminal investigations. I labelled their condition as Ganser state, while recently Whitlock has mentioned the possibility "that a proportion of these cases could have been instances of hysterical pseudodementia rather than true examples of the Ganser syndrome". In my paper I also introduced the possible element of organicity.

Now the scope of interpretation of the pathogenesis in the case B. has been narrowed down by Zangwill almost to its limit, under the circumstances. However, I feel that the psychodynamic factors advocated by Syz (1936) and by Völkel and Stolze (1956), although not proven, may add to our understanding and approach to similar cases in the future. If speculation is at all permissible, one might come up with the following ideas:

1. Prior to his accident, the patient B. had been under considerable stress (venereal disease as a practising Roman Catholic; engagement to a much older woman). Was he not in great need of an escape into a psychoneurotic condition?

2. The patient was found unconscious at 1 a.m. at his place of work, apparently under the influence of escaping coal-gas. Was anything known in greater detail about the circumstances of this accident? Could the possibility be ruled out that the accident was in any way the result of the patient's conscious or unconscious need for an accident, not necessarily by his directly causing it but e.g. by his neglecting to take the usual precautionary measures, such as proper ventilation?

3. If these speculations are plausible to any extent, they would only parallel Zangwill's suggestion "that the hysterical elaboration of the memory defect may have arisen in the early stages of the illness within the context of an organic confusional state", in that the path for the developing symptom was pointed to by the usual memory loss due to transient brain damage.

MILO TYNDEL.

Research Psychiatrist, Addiction Research Foundation.
Research Associate, Department of Medicine,
University of Toronto, Toronto, Ontario, Canada.

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SIDE-EFFECTS OF PHENOTHIAZINES

DEAR SIR,

The "bogey" of the side-effects due to fluphenazine (moditen) appears to me to be exaggerated. In his review of almost 4,000 patients on oral phenothiazines, Ayd (1) found an incidence of extrapyramidal side reactions in 60 per cent of patients taking trifluoperazine (stelazine) and in 52 per cent of patients taking fluphenazine. None of these patients were taking any anti-parkinson drug. Thus trifluoperazine in such circumstances has a similar incidence of side-effects of this nature to fluphenazine, despite the fact that the latter is a far more potent phenothiazine.

With regard to the increased incidence of dystonic reactions when phenothiazines are given parenterally, I think one must differentiate between short-acting parenteral phenothiazine preparations and, as far as I know, the only long-acting one—namely fluphenazine enanthate. My experience has been mainly with the latter, and in a small series of some 68 patients treated with this drug in the past 14