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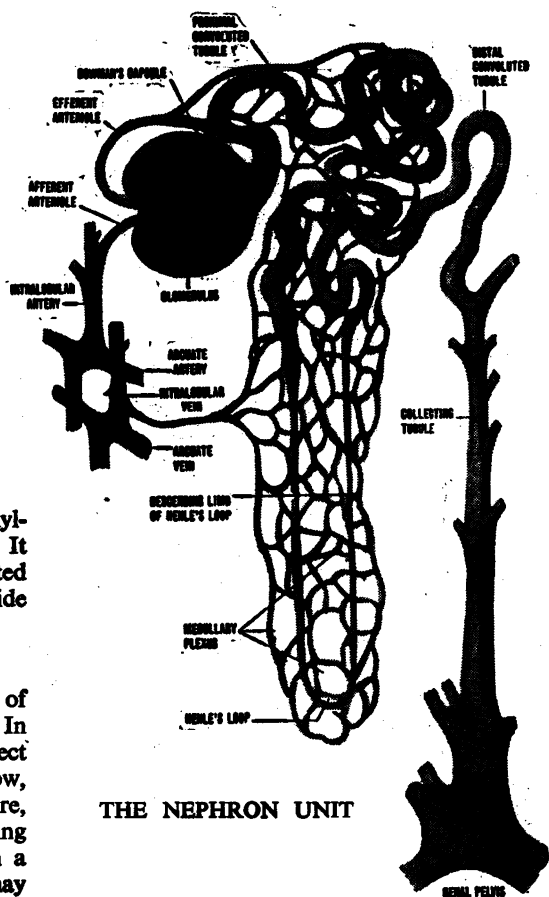
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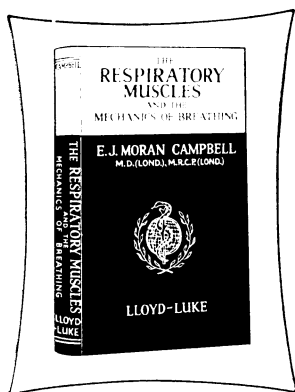
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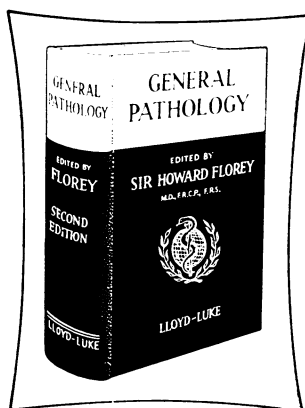
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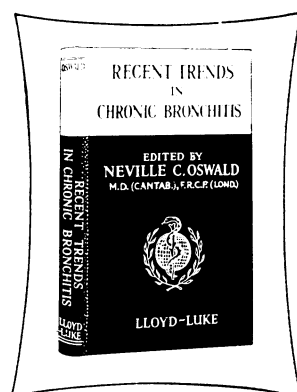
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Individual responses are extremely variable and the dose must be determined for each patient. Dosage up to 2,000 mg. a day can be tolerated by adults, though at these levels Parkinsonian symptoms may develop. It is usual to begin with 75 mg. or 100 mg. daily by mouth, gradually increasing the dose as necessary. There is probably no advantage in exceeding 600 mg. or 800 mg. daily.

For rapid action the intramuscular or intravenous routes should be used. The 2.5 per cent. solution should be diluted about 10 times with saline before being injected intravenously. Deep intramuscular injection is well tolerated, though it may occasionally cause pain at the site of the injection. The elixir of chlorpromazine (4 ml. contains 25 mg.) is rapidly absorbed and in some instances is more effective than tablets.

Chlorpromazine can be combined with other physical treatments, such as insulin coma and E.C.T. For prolonged sleep chlorpromazine may be combined with barbiturates, such as amytal and phenobarbitone, and anti-histamines, such as phenergan, and in physically fit adults may be continued up to a month without difficulty.

Side-effects

These are frequent and for this reason it is

doubtful if it is suitable for patients outside hospital, except under careful supervision. Dizziness, palpitations, shivering, lethargy and colicky abdominal pains are all common, but usually pass off after a few days' treatment. Skin rashes are more serious, but jaundice and agranulocytosis are the complications most to be feared. Large doses may produce a Parkinsonian syndrome, and the drug is also mildly epileptogenic. As a rule complications are not serious and disappear when the dose is reduced or administration discontinued. Surprisingly, they do not usually recur when the drug is restarted.

Jaundice may be due to intra-hepatic obstruction and any interference with biliary drainage may predispose to this complication. Chlorpromazine should therefore probably not be given where there is a history of liver disease.

When lethargy and weakness are a problem chlorpromazine may be reduced or combined with either d-amphetamine or phenidyl-acetate (Ritalin).

It must also be remembered that this and similar drugs potentiate the effect of barbiturates and alcohol and should not be given when unknown quantities of these have been taken. A contact dermatitis or a photosensitization reaction may be a troublesome complication where staff repeatedly handle chlorpromazine (Lewty, 1955).

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Conclusion

Foetal hypoxia is responsible for a large proportion of stillbirths and neonatal deaths and considerable morbidity in the neonatal period.

Prevention of the conditions which cause hypoxia must be the ultimate aim and progress is being made. In the meantime, much work is needed on the mechanisms by which hypoxia leads to neonatal morbidity and death, so that better treatment for infants with respiratory difficulty after birth can be devised.

The prognosis of foetal hypoxia is not yet clear, but it appears likely that the risk of impaired neurological function in later life is small in most cases.

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Summary

1. The clinico-pathological features of calcinosis are discussed.

2. It is emphasized that in all cases a primary condition should be assiduously sought.

3. Four cases of soft-tissue calcification are described; in three of these cases there was evidence of a primary collagen disorder and in the fourth case the calcification was secondary to chronic renal failure.

Acknowledgments

I wish to express my sincere thanks to Prof. Bryan McFarland for his very great help and interest. I am also deeply indebted to Mr. G. Shatwell, Dr. G. S. Sanderson, Dr. S. Keidan, Mr. G. V. Osborne, Dr. R. W. Brookfield and Dr. E. L. Rubin and also Mr. A. G. O'Malley for allowing my access to their records and cases and for their kind permission to publish their cases.

Case No. 3 has been the subject of an article by Dr. R. W. Brookfield, Dr. E. L. Rubin and Dr. M. K. Alexander in the *Journal of the Faculty of Radiologists*, 7, 2, 1955.

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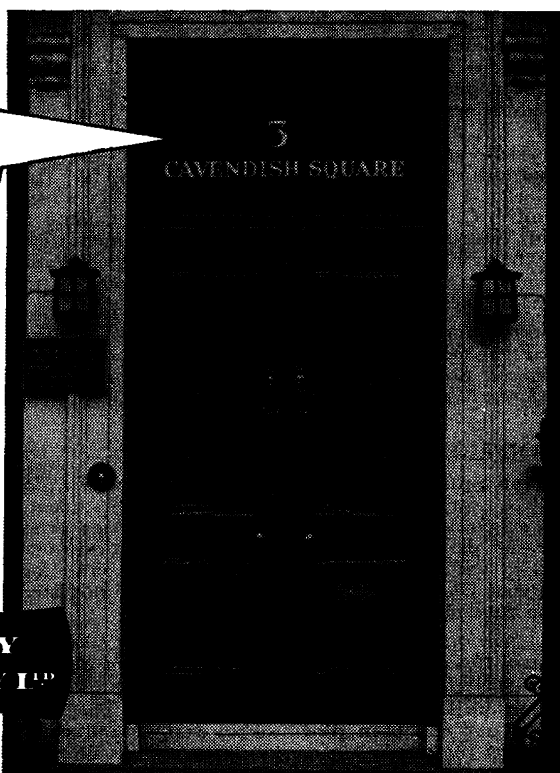
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