

A Drug of Abuse—Mandrax

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Methaqualone was first synthesized in India in 1951 and developed as a potential anti-malarial drug. Later its soporific effects were explored. In 1965 the drug was combined with an anti-histamine diphenhydramine to produce a more potent sedative/ hypnotic and was marketed by Roussel under the name of Mandrax (methaqualone 250 mgm: diphenhydramine 25 mg.).

The first indications of drug abuse were reported within a matter of weeks of Mandrax reaching the market, but due to the widespread abuse of barbiturates they went largely unnoticed. Now the drug is perhaps only second to Mogadon (nitrazepan) as a non-barbiturate sedative/hypnotic in the large quantities prescribed. There are however good reasons why this particular drug combination ought to be prescribed by doctors with the utmost care.

They are:

- 1) One pill a day for two months is likely to produce physical dependence.
- 2) Prolonged use of the drug does cause physical tolerance and psychological dependence similar to that of barbiturate dependence.
- 3) Withdrawal of the drug can result in death. It should be carried out in hospital. Initial withdrawal symptoms are headaches and severe cramps followed by convulsions. Haemorrhages from the stomach may follow in three to five days.
- 4) Dependency symptoms include irritability, sleeplessness, delirium tremens, mania and epileptiform attacks. If convulsions are not treated, status epilepticus may develop.
- 5) Amongst the adolescent drug misusers Mandrax is known as 'mandies' or 'randy mandies'. It has a pleasant high if the subject stays awake and it is reported (as barbiturates also are in this group) to have an aphrodisiac effect. Due to the marked incoordination produced by Mandrax misusers are known also as 'wall bangers' because of their propensity for walking into solid structures.
- 6) In relatively small overdoses or especially in combination with alcohol it can prove fatal even with the best efforts at resuscitation. Prolonged coma and hypotension with small overdoses is a feature.

Roussel are reported to have stated in relation to the U.K. market that 'because of the abuse problem, we have undertaken no direct promotion of Mandrax for the past two years. In 1972, we withdrew the 1000 pill pack and are withdrawing the 100 pill pack on May 1. It will then be available in packets of 30 to reduce the danger of thefts from chemists and overdoses.

We are in favour of tighter controls. Mandrax should be under lock and key in Chemists shops.' In the recent Irish Mims it is noted the price is still quoted for 100 bottles.

The Department of Health has all drugs which may be liable to abuse, including this particular drug under scrutiny and when the new Misuse of Drugs Bill becomes operative as an Act there will be provision for reclassification of any drug if this is thought to be desirable.

In the Drug Advisory and Treatment Centre and in the Casualty Department of Jervis Street Hospital, this particular drug together with the barbiturates causes most concern in the overdose cases.

The drug is also marketed under the following names—Lancesommal, Matthodorm Paldona, Paxidorni, Melsed, Quaalude, Revennal and Sedaquin.

Mandrax is sold in tablet and capsule forms. The tablet is white—marked Mx on the face and R/L on the reverse.

The capsule which is the same strength as the tablet is dark and bright blue marked Mx/RL.

Drug abusers in Ireland misuse Mandrax by both the oral and the intravenous routes.

ADDENDUM

Since writing this I have now come across a letter by Dr William Sergeant of St Thomas's Hospital, London, on page 716, of the British Medical Journal—23.6.73.

It would seem fair to me to make some comment on his views of the selected use of drugs which are liable to abuse. One can quite easily understand that he may prefer the drug Mandrax in prolonged states of narcosis, with or without intensive electro-convulsive therapy, but as he rightly points out—'If one uses Mandrax or Mogadon, one should give only one tablet, if possible, as a sedative at night' ... one can also start with Mogadon, and use Mandrax, if the former does not work, *preferred often to the barbiturates*. One must agree with Dr Sergeant when he advocates the skilled, selective, clinical use of drugs.

One final comment, Dr Sergeant's patients are a vastly different group from the very young, inadequate drug abusers which are seen at the special Drug Treatment Centres in the Republic of Ireland and the United Kingdom, and whilst I am not advocating a ban on a useful drug, I am merely suggesting that fewer and smaller prescriptions of the drugs, plus more drug education, plus more locked cupboards might help us with the co-operation of the very responsible Pharmaceutical Company, to avoid Medical Drug Casualties in the very young.