DEPENDENCE ON GUL: AN INDIGENOUS COMPOUND CONTAINING TOBACCO

Sir,

Gul is an indigenous dental powder available in the eastern states of India. It is made of tobacco leaves which are powdered and mixed with some hitherto unknown ingredients. It is used by rubbing it on to the teeth and gums with the fingertips or less commonly, with tooth brushes. It is widely abused in the towns and villages of the state of Bihar and some districts of West Bengal and Orissa.

Gul abuse is prevalent in all socioeconomic groups, but more so in the middle and lower classes. It is commoner in females, in the young and the middle aged. The usual brushing of the teeth in the mornings and before retiring to bed is replaced with 'gul rubbing' by the users. They also rub it when they feel anxious, depressed or overburdened with work. Many of them rub it several times, even up to 50 times a day. Although use of gul for cleaning the teeth is acceptable in society, overindulgence is perceived as an addictive behavior.

An eighteen year old female was admitted to our institute for the treatment of gul dependence. She was in the habit of using gul 40 to 50 times a day. The parents became worried with this excessive indulgence as all her activities centered around procuring gul. They were also worried that this would adversely affect her physical health. They tried to stop this behavior, but it only resulted in the patient becoming irritable and quarrelsome. In the hospital she developed withdrawal symptoms in the form of intense craving, restlessness, vomiting, sleeplessness and marked irritability. She had no other diagnosable psychiatric problem nor had any other psychoactive substance abuse. The withdrawal symptoms were managed with clonidine and tapering doses of diazepam. She was asymptomatic within a fortnight and was discharged after about a month. She did not report for follow up.

Smoking by females is looked down upon in our culture, but the use of tobacco in the form of gul is socially sanctioned and the user is able to indulge in this behavior in the guise of cleaning one's teeth. Only rarely it is recognized as a problem as in the case mentioned above. Though a large proportion of the population in the eastern states of India abuse this compound (which may contain other dependence producing substances also), no report has yet been published regarding the abuse of this product. This
may be because cases of ghee dependence are usually not brought for consultation to the psychiatrists. It has been our experience that there is usually an increase in the symptomatic abuse of this product in psychotic disorders and episodes of depressive illness. This report is an effort to bring to the notice of researchers in the field of psychiatry and related fields, the endemic abuse of this substance - a hitherto unrecognized but widely prevalent problem.

Sayeed Akhtar
Christoday R.J. Khess
Central Institute of Psychiatry
Kanke, Ranchi 834 006.

PHYSICAL MORBIDITY AND UNMODIFIED ECT

Sir,

We read with interest the article by Drs. Tharyan et al (Journal, Oct 1993). It is a commendable attempt at documenting the experience with unmodified ECT in a center that has been compelled to use the same under severe resource constraints. It offers a useful body of information to other psychiatrists, in a similar predicament, who have no choice but to make the best of a bad situation, conscious of the limits of safety. The authors, however, have deflected the debate by telescoping into their discussion issues of desirability and comparability vis-a-vis the currently accepted standard of modified ECT. It appears that in their anxiety to legitimize unmodified ECT and reassure themselves, they have exceeded the limits of valid inference.

They observed that unmodified ECT in a selected population (after screening out those requiring modified ECTs) is not very unsafe except for fractures in about 0.8% of patients. Although they recorded one death with cardiac arrest, the authors comment that the treatment is safer than modified ECT. This remark we opine is without sufficient basis. First, the two ECT comparisons were not strictly random. Second, by virtue of screening some patients for only modified ECT, this group is different from the larger unmodified ECT group. As can be seen by their data, the upper age range in the modified ECT group was 70 years whereas it was 50 years for the unmodified ECT group. Third, the modification procedures are not clearly described, e.g., the dose of atropine if used should have been given.

The authors have not made a data-based case to justify the implication that "the recommendation to routinely give only modified ECT requires further review". The debate needs to be addressed with truly comparable data, on both morbidity and acceptability of the two procedures. Meanwhile, psychiatrists owe to their patients to advocate and strive to offer them the best current standards of care including modified ECT.

B. N. Gangadhar
N. Janakiramaiah
Department of Psychiatry
NIMHANS
Bangalore 560 029.

REFERENCE

Tharyan, P., Saju, P.J., Datta, S., John, J.K. & Kuruvilla, K. (1993) Physical morbidity with unmodified ECT - a decade of experience. Indian Journal of Psychiatry, 35, 4, 211-214.

THARYAN ET AL REPLY

Sir,

We appreciate the interest shown by Gangadhar & Janakiramaiah in our paper on unmodified ECT, the main aim of which was to stimulate a debate on the routine use of modified ECT in this country, given the paucity of anaesthetic and resuscitative facilities in many centers where ECT is administered. However, their comments on the validity of our inference appear based primarily on the assumption that the patients in our study treated with modified ECT were older and less physically fit than those treated with unmodified ECT.

The first assumption is erroneous as the data in Table 1 of our paper clearly states that the upper age range of 70 years and 59 years pertain to patients treated with unmodified ECT, who experienced myalgia or fractures respectively, and not to patients given modified ECT. The difference in the mean ages of patients in the two treatment groups was not significant. The second assumption is partly true in the observation that patients in our series treated with modified ECT had a higher prevalence of pre-existing musculoskeletal complications; however, as highlighted in our paper, unmodified ECT was