A 39-year-old married graduate bank employee, started drinking and smoking cigarettes since 1995. In December 2003, when his mother was admitted in the coronary care unit, a paramedical worker in the hospital casually commented on his ‘cold limbs’ and advised him to take intravenous (IV) mephentermine, as that person said he was using the same drug for a similar purpose. Following an IV dose administered by his unsolicited advisor-cum-peer, he perceived ‘stimulation in nerves’, increased energy and pleasurable sensations. After two months of irregular use, he started taking 2 ml Termin® (15 mg/ml preparation of mephentermine) IV twice daily regularly (60 mg/d). He gradually started craving the drug and reported a sense of compulsion to continue taking it.
From the middle of 2004 onwards, he experienced withdrawal features in the form of decreased pulse rate and blood pressure, restlessness, cold extremities, sweating, anorexia, irritability, and insomnia. There was evidence of harm in the form of multiple injection-related skin infections and repeated withdrawal-related hypotensive episodes. Despite this, he found it difficult to stop taking the injection or reduce its dose. Presence of these withdrawal features, along with the continued perception of the stimulant effect of the drug, made him continue with this on a regular daily basis until December 2005. He would use capsule Proxyvon off-and-on since 2004, only as a ‘substitute drug’ when Termin was not available or affordable.

From this scenario, by late December 2005 he was initiated into the use of injection buprenorphine with pheniramine and diazepam, as he discontinued mephentermine, not by choice but due to unavailability and increased cost. He quickly became dependent on the combination, was brought to our de-addiction centre in October 2006, and eventually hospitalized for de-addiction.

Two earlier reports were of mephentermine misuse without evidence of dependence.\(^1,2\) In both the reports, misuse of mephentermine inhaler induced short-lasting acute paranoid-hallucinatory psychosis, similar to amphetamine psychosis. Later, one case of mephentermine dependence associated with a chronic psychotic illness was reported.\(^3\) In the fourth case report, mephentermine use was reported only in combination with buprenorphine and promethazine, apparently to counteract the hypotension caused by the latter.\(^4\) Thus, although its misuse has been reported in the context of psychotic illness, a true mephentermine dependence syndrome without associated psychosis has not been reported.

Our patient clearly demonstrated ICD-10 substance dependence syndrome by meeting four out of six criteria for nearly two years: strong desire or sense of compulsion to use the substance, impaired control, withdrawal, and persistence despite harm.\(^5\)

Thus, this case report shows that, although rarely reported, mephentermine use can cause dependence especially in an individual with multiple substance use, even without precipitating or occurring in the context of an amphetamine-like psychotic illness. Given its potential of causing harm due to hypertension, the abuse and dependence liability of mephentermine needs to be highlighted.

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REFERENCES
4. Mendhekar DN, Sharma H, Dali JS. Case report


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Sir,

There are many reports on ocular motility disturbances caused by neurocysticercosis of brainstem [1-3] and fourth ventricular neurocysticercosis cyst [4] in the available literature, but isolated one and a half syndrome due to neurocysticercosis has not been reported. We describe a patient with one and a half syndrome without any other brainstem signs, caused by neurocysticercosis involving the pons.

An 18-year-old male presented with a history of sudden-onset diplopia of 1-week duration and blurring of vision. He had no history of headache, fever, seizures, walking difficulty, previous head injury, diabetes or hypertension. There was no history of a similar episode in the past. Diplopia was found increased while looking to the left. Findings from general examination were normal. The left eye was deviated outward, and the right eye was central in primary gaze. There was weakness of adduction in the left eye and paralysis of all conjugate horizontal eye movements in the right eye. The left eye also showed nystagmus while the patient attempted left lateral gaze. Vertical eye movements were normal, and no ocular bobbing was observed. There was no long tract sign, and the cerebellar system was normal. The remainder of the examination was unremarkable.

Findings from routine blood examination, including blood biochemistry and chest X-ray, were normal. Mantoux test was negative. Cerebrospinal fluid (CSF) analysis revealed a clear fluid with leukocyte count of 2/mm³; protein, 25 mg/dL; and CSF glucose, more than 50% that of serum. Findings from direct examination and culture of CSF were negative for acid-fast bacilli fungal and bacterial pathogens. Computed tomography (CT) and magnetic resonance imaging (MRI) sections showed a small ring-enhancing lesion in the dorsomedial pons [Figures 1 and 2]. CSF for adenosine deaminase assay was negative, and enzyme-linked immunoabsorbent assay for anticysticercal antibodies (IgM and IgG) in cerebrospinal fluid was positive. A diagnosis of neurocysticercosis was made, and the patient was treated with albendazole and dexamethasone. The patient showed

Figure 1: CT scan of the brainstem showing a granuloma in the dorsomedial pons