

stated that "No clear case of addiction to d-amphetamine has been reported."

However, Leake admitted at the very end of his book that he had not become aware of the Japanese situation until "this book was in galley proof."

During World War II millions of Japanese soldiers, aviators, sailors, and civilians engaged in defense, munitions, and government work took tons of "wake-amines," especially methamphetamine—sold as "philipon."

After the war military stockpiles of amphetamines flooded an exceedingly depressed and disillusioned but determined and growth-oriented civilian population, and the immediate result was the overnight eruption of an unprecedented epidemic of drug abuse and addiction.

By 1954 it was estimated that there were 500,000 to 1.5 million Japanese amphetamine abusers, about half genuinely addicted.

Despite the minimization of the amphetamine abstinence syndrome in the medical and lay press, and the parallel exaggeration of the unpleasantness of the average heroin addict's abstinence syndrome, withdrawal from amphetamines can be most distressing.

Since the individual who is "crashing" from high-dose amphetamine abuse appears to be sleeping well a good deal of the time, he is often considered to be merely exhausted.

But the picture of the amphetamine abstinence syndrome that has recently emerged is as unpleasant and painful as the traditional reputation of heroin withdrawal.

Extreme lethargy, fatigue, anxiety, terrifying nightmares, and suicidally severe depression are common.

The individual is usually completely disoriented, bewildered and confused. He is apt to be extremely irritable and demanding—which drives people away just when he most needs their help.

His psychic disruption and loss of self-control may lead to violent acting out of aggressive impulses. He has headaches, he has trouble breathing, he sweats profusely, and his body is racked with alternating sensations of extreme heat and cold and excruciating muscle cramps.

He characteristically suffers painful gastrointestinal cramps. Especially if he is alone, and despite his sometimes incredible hunger, he often lacks the strength to eat at all, aggravating his condition through malnutrition.

As early as 1935 reports began to appear in medical journals suggesting that "Benzedrine" might cause serious cardiovascular disturbances. The following year the first such concrete evidence was published by E. W. Anderson and W. C. M. Scott, who administered "therapeutic" doses—10 to 30 milligrams—of "Benzedrine" to 20 "physically fit" and "normal" subjects in a controlled laboratory experiment.

Almost without exception their subject exhibited pallor and flushing, palpitations, and changes—usually marked increases—in pulse rate and blood pressure.

Now, 10 to 20 milligrams is not an uncommon dose for someone to take who is being treated for obesity.