A case of neuroleptic malignant syndrome successfully treated with amantadine has been reported (McCarron *et al*, 1982). Amantadine, which lacks significant anticholenergic action, is thought to increase synaptic dopamine availability, which may account for its effectiveness. Recently two cases were successfully treated with electro convulsive therapy (Jessee & Anderson, 1983). ECT was initiated because of the clinical deterioration that resulted from prolonged immobility and high fever. It resulted in dramatic reduction of fever and the beginning of overall clinical improvement. It seems that in cases where there is continued clinical deterioration or life threatening fever, in spite of the usual supportive measures, ECT should be considered in the treatment of neuroleptic malignant syndrome.

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DEXAMETHASONE SUPPRESSION TEST: DIFFERENT CATEGORIES OF RESPONSE

DEAR SIR,

The dexamethasone suppression test (DST) has been subjected to considerable research in the last twenty years. Carroll (1982) reviewed research in this area and concluded that the DST is a state-dependent biological marker which differentiates endogenous depression from other psychiatric disorders with a sensitivity of about 50% and a specificity of 96%.

On the basis of one DST result, patients are categorised as non-suppressors or suppressors, non-suppression being defined as a post-dexamethasone cortisol concentration of greater than 5 μg/dl (138 nmol/l), (Carroll *et al*, 1981). Despite the increasing use of serial DST's, (Albala *et al*, 1981; Holsboer *et al*, 1982, and Greden *et al*, 1983), this dichotomous categorisation has remained unquestioned. In a study involving serial DST's, I have found this categorisation to be inadequate, and have been able to define at least 3 distinct categories of serial DST response.

Thirty-six patients with a diagnosis of primary depressive illness were studied. A DST was performed before treatment and then weekly during a six week treatment period, with simultaneous ratings on the Montgomery and Asberg Depression Rating Scale (MADRS).

On the basis of the serial DST results, the following categories were identified:—

1. NORMALISING NON-SUPPRESSORS characterised by initial non-suppressor DST response which subsequently converted to and remained a suppressor response.
2. FLUCTUATING NON-SUPPRESSORS characterised by DST results fluctuating between suppression and non-suppression.
3. PERSISTENT SUPPRESSORS characterised by a persistent DST suppression response.

All three groups showed clinical improvement and the two non-suppressor groups both showed a significant reduction in post-dexamethasone cortisol concentrations during the treatment period, i.e. normalisation occurred. However, the two non-suppressor groups differed in two respects. The final post-dexamethasone cortisol concentrations of the fluctuating group were significantly higher when compared with the other groups, and when a Pearson's correlation was performed only the normalising non-suppressors had a significant correlation between post-dexamethasone cortisol concentrations and simultaneous MADRS scores—see table.

Correlations between weekly post-dexamethasone cortisol concentrations and simultaneous MADRS scores

Category	Pearson's r
Normalising non-suppressors	0.5350 ($P < 0.001$)
Fluctuating non-suppressors	0.1849 (NS)
Persistent suppressors	0.0034 (NS)

These findings appear to support the distinction, made in the above categorisation, between normalising non-suppressors and fluctuating non-suppressors. The longer term prognostic implications of these groups require further investigation.

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CORRECTION

The letter headed "Prediction of Response to ECT" (*Journal*, June 1984, **144**, 670) was written in conjunction with Professor George W. Ashcroft, Aberdeen University and Dr Klaus P. Ebmeier, Royal Cornhill Hospital whose names were inadvertently omitted.

ADDENDUM

DEAR SIR,

It has come to our attention that in our article "Past and Present Perceived Attitudes of Schizophrenics in Relation to Rehospitalization" (*Journal*, March 1984, **144**, 263–9), we neglected to mention that in the Influential Relationships Questionnaire (IRQ) the Care Scale scores are inverted. Thus, a score of six on the IRQ would equal a score of thirty on the Parental Bonding Instrument (PBI). For Maternal scores rated twice, the PBI Care scores have also been inverted to achieve equivalency. We apologise for this ommission.

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Book Reviews

Hysterical Conversion Reactions: A Clinical Guide to Diagnosis and Treatment. By MICHAEL I. WEINTRAUB. Lancaster, Lancs: MTP Press. 1983. Pp 145. £17.95.

This is the first in a series of volumes planned by neurologists to familiarise others with common clinical disorders and to emphasise examination techniques, pitfalls, investigations and treatment. In this case the Editor-in-Chief of the series is also the author. He begins with a brief historical introduction of dubious value and containing a number of inaccuracies. Minor ones include spelling wrongly or misprinting the *Kahun Papyrus*, the Greek for uterus and the name of Marmor. It is more troublesome that he quotes a good article by Smith-Rosenberg without giving the reference. He also misses an important aspect of the work of Charcot when he says that Charcot did not recognize the importance of psychological conflicts, but fails to note that Charcot described a psychological basis for hysteria as well as its similarity to hypnotic suggestions. Similar failings appear on page 19 where details of a follow-up study of alleged malingerers are given without a reference and on page 20 where Asher's term of Münchausen's syndrome is introduced without the original reference or explanation of the name, but with quotation of his cumbersome categories which are derogatory to the patient. Similar irritating slips or inadequacies appear recurrently throughout the book. On page 51 the author says that the descriptions of pain in psychological illness are vivid, although we have known at least since Gittleson's 1961 study that that is often wrong. On page 52 the argument would have been greatly strengthened by reference to the follow-up studies of MacNab and of Mendelson in accident cases. As late as page 92 the author dismisses the prolactin test for hysterical seizures on the grounds of the assay being unreliable without citing Trimble's paper which described it, and perhaps without knowing that a most impressive differentiation between patients was shown with that measure. He also calls epileptic seizures "true" in contra-distinction to hysterical ones.

Yet I am glad to have this book, will keep it handy for referral for various purposes, used it in that way on the morning of preparing this report, and recommend it to other psychiatrists. This is because in the middle part of the book the author does what he has promised in the first part. He gives clear and impressive demonstrations of the methods of clinical examination which show the presence of hysterical symptoms.