

His psychotic symptoms continued and his behaviour was highly disturbed, involving damaging furniture and being assaultive. He was transferred to a special (high-security) hospital. Despite treatment with various traditional antipsychotic medications, he made no improvement for three years.

A trial of risperidone was discontinued when blood sugar levels were noted to be elevated. They remained elevated after withdrawal of risperidone. Control of his diabetes was achieved using an oral hypoglycaemic (glibenclamide). In the two years since traditional antipsychotic and oral hypoglycaemic medications have been prescribed together, he has continued to experience psychotic symptoms but has not acted violently. He was returned to the medium secure unit.

Increased irritability is a reported psychiatric aspect of diabetes (SurrIDGE *et al*, 1984). We question whether his latent diabetes may have made him less able to control his behaviour in response to psychosis. Conventional antipsychotic medication only became effective in controlling his violent behaviour after his diabetes was stabilised. Could latent diabetes be an unrecognised cause of treatment resistance in schizophrenia?

Hagg, S., Joelsson, L. Mjorndal, T., et al (1998) Prevalence of diabetes and impaired glucose tolerance in patients treated with clozapine compared with patients treated with conventional depot neuroleptic medications. *Journal of Clinical Psychiatry*, **59**, 294–299.

Popli, A. P., Konicki, E. P., Jurjus, G. J., et al (1997) Clozapine and associated diabetes mellitus. *Journal of Clinical Psychiatry*, **58**, 108–111.

SurrIDGE, D. H. C., Williams Erdahl, D. L., Lawson, J. S., et al (1984) Psychiatric aspects of diabetes mellitus. *British Journal of Psychiatry*, **145**, 269–276.

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Mirtazepine causing hyperphagia

Sir: We report a case of hyperphagia occurring following the introduction of mirtazepine.

A 56-year-old married woman suffered from an episode of severe depression that had lasted for over two years. The illness had been precipitated by a range of family stresses and her condition was exacerbated by further personal trauma. A prominent feature of her depression was loss of appetite, which resulted in marked loss of weight. On a number of occasions she was at risk of developing electrolyte imbalance due to restricted fluid intake. Treatment with a range of antidepressants with and without lithium augmentation proved ineffective, and three courses of electroconvulsive therapy (ECT) produced only temporary improvement. She was started on mirtazepine and the fourth course of ECT. Six days following the start of mirtazepine her appetite showed a dramatic improvement. This became particularly clear when the dose was increased to 45 mg/day. Sixteen days after the start of treatment she started eating excessively large quantities of food as well as showing inappropriate eating behaviour, such as eating leftovers from other patients' plates, attempting to take food from wastepaper bins, attempting to pick up food from the floor, and taking food from other patients'

dormitories. She was also bingeing on biscuits, chocolates, cake and crisps.

Her weight increased by 10 kg within a period of four weeks. Her eating behaviour started to settle over the next two weeks but her appetite remained excessive. The bingeing behaviour gradually declined and the inappropriate eating behaviour stopped completely.

The voracious appetite seemed more settled when she was reviewed a week later but she still showed occasional binge eating. Her mood showed progressive improvement over a period of four to six weeks for the first time in two years.

This case of hyperphagia lasted for two to three weeks in a patient recovering from a chronic depressive disorder. This coincided with the introduction of mirtazepine while also undergoing ECT. Mirtazepine is known to increase appetite and weight. According to the manufacturer's database, there has been one previous reported case of hyperphagia, in a 54-year-old woman two weeks after commencing the drug, and settling after its withdrawal. In the present case, the hyperphagia also started after about two weeks but was self-limiting despite continuing with mirtazepine at the same dose. It is of interest that, in this case, the marked reduction in appetite was a prominent feature of this patient's depressive illness and that the improvement in mood and appetite eventually occurred simultaneously. This raises the question of whether mirtazepine may have a special therapeutic role in severely depressed patients who also show severe reduction in their food intake.

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One hundred years ago

The Medico-Psychological Association of Britain and Ireland

The fifty-eighth annual meeting of this association will be held in London on July 27th and 28th, at the society's rooms, 11, Chandos-street, W., under the presidency

of Dr. J. B. Spence. The presidential address will be delivered in the afternoon of the first day and will be followed by the conferring of medals and distribution of prizes presented by the association, after which a paper upon Christopathia and Bibliopathia, or the Psychopathy of

so-called Christian Science, will be read by Dr. C. H. Hughes, President of the Faculty, and Professor of Neurology and Psychiatry of the Barnes Medical College, St. Louis, U.S.A. On Friday demonstrations and papers will be presented by (among others) Dr. F. W. Mott, F.R.S.,