DEAR SIR,

As a middle-of-the-road, eclectic psychiatrist I am not usually given to graphic demonstrations, but I feel constrained to voice my feelings, like others have done, concerning the College Memorandum on ECT (*Journal*, September 1977, **131**, 261–72).

For some time now I have watched the onslaught on orthodox psychiatric methods by the NAMH and more recently by mass media, which seem to imply that consultant psychiatrists are at worst evil people, or at best stupid people, who do not have the best interests of their patients at heart.

Like others I waited impatiently for a rebuttal of such allegations by our chosen representatives (i.e. The Royal College), but, instead, in their eagerness to mollify the detractors, they pen the infamous Memorandum which partly states the obvious, and partly joins in the attack against, and successfully creates chaos out of confusion.

In my opinion Dr S. Spencer (*British Journal of Psychiatry*, Vol. **131**, December 1977) was correct in his denunciation of the Memorandum and represents the majority view of consultant psychiatrists in this country. It is a pity the committee formulating the Memorandum did not have a twinge of humility and did not canvass the views of the consultant psychiatrists of this country before pontificating on the subject. It is not too late for this to be done and published. How can a committee that professes concern for psychiatric patients and their liberty suggest that what is currently carried out under the umbrella of a 28-day compulsory order should be changed to give *the same treatment* under an order lasting *one year*!

It seems obvious to me that the major motivation for most of the advice given in the Memorandum was self preservation of psychiatrists, using legal 'belt and braces' methods.

A brief word regarding the Editor's comments in the same issue of the *Journal*.

The message came over as didactic and condescending and perhaps he should be reminded that the principle of the 'super-consultant' was laid to rest when medical superintendents were officially phased out.

He knows, as we all do, that the 'advice' of the Royal College today becomes the standard practice acceptable tomorrow—perhaps part of his difficulty is that living in his postgraduate ivory tower, he is somewhat divorced from the realities of the workaday psychiatry world, and therefore sees the problem as the simplistic decision between politeness and impoliteness.

The Editor does not have the monopoly of 'humanity, courteousness, or compassion', or any other decent human emotion, and it is perhaps apt to quote the aphorism 'patriotism (or in this case 'lofty ideals') is the refuge of the scoundrel'—or rather its use in public speech is!

J. CRAUSE

St Matthew's Hospital,
Burntwood,
Nr Lichfield, Staffs

ELECTROCONVULSIVE THERAPY AND THE DEAF

DEAR SIR,

Dr W. G. Charles writes in the November issue (*Journal*, **131**, 551) about the effect of ECT upon nerve deafness and tinnitus.

Over the space of about 20 years I recall seeing three or four such patients who have complained of increase in tinnitus and/or deafness following ECT. I have never seen any reference to it in the literature nor have I found that my ENT colleagues were conscious of the problem. I am uncertain whether the effect is permanent and, on one occasion, have had to give further ECT to such a patient withot receiving further complaints of that nature.

E. HOWARTH

Doncaster Royal Infirmary,
Doncaster DN2 5LT

SELF-POISONING

DEAR SIR,

At the Annual Meeting of the College in July 1977, I presented the results of a clinical trial designed to answer the question: is a specialist psychiatric assessment necessary in all cases of deliberate self-poisoning?

We found (1) that, if given suitable teaching, medical teams can evaluate the suicidal risk and identify patients requiring psychiatric treatment or help from social workers, or both. We concluded that a more selective approach towards the psychological and social evaluation of such patients is preferable to the Department of Health's recommendation (2, 3) that in all cases of deliberate self-poisoning patients should be seen by psychiatrists. If a recent 'Horizon' programme on the BBC is accurate, at least 100,000 such patients are admitted to our general hospitals each year. Taking an average 25 per cent for the number of patients who may discharge themselves from medical wards before being seen by psychiatrists, perhaps 75,000 patients receive a specialist psychiatric evaluation each year.

Our study at Addenbrooke's suggests that only 15,000 of the 75,000 patients really require this specialist assessment.

I am concerned lest psychiatrists should now leave hard-pressed physicians to undertake the initial psychiatric assessment of such patients without first ensuring that junior doctors and nurses receive instruction in this work and that psychiatric treatment and help from social workers are available once patients are discharged. What should be taught, and how consultation-liaison can be achieved, merit wider discussion.

May I restate two proposals made six months ago The first is that we invite the College of Physicians to join us in a meeting which would consider in detail teaching and liaison. The second is that we ask the Standing Medical Advisory Committees not only to review the arrangements for the treatment and after-care of self-poisoned patients, but also to initiate a detailed study of the prevention of poisoning. It will be recalled that the committee chaired by Professor Sir Denis Hill (3) met a decade ago and was unable to include the prevention of poisoning in its remit.

One of the aims of such a committee could be to formulate questions for which we need to find specific answers and then to advise the Department of Health about funding the appropriate research. In this way we might achieve a more favourable balance 'between guesswork and certainty'.

R. GARDNER

Self Poisoning Unit,
Addenbrooke's Hospital,
Cambridge CB2 2QQ and
Fulbourn Hospital,
Cambridge CB1 5EF

References

1. GARDNER, R., HANKA, R., O'BRIEN, V. C., PAGE, A. J. F. & REES, R. (1977) Psychological and social evaluation in cases of deliberate self-poisoning admitted to a general hospital. *British Medical Journal, ii*, 1567–70.
2. MINISTRY OF HEALTH, HM (61), 94.
3. CENTRAL AND SCOTTISH HEALTH SERVICES COUNCILS (1968) *Hospital Treatment of Acute Poisoning.* London: HMSO.

MIANSERIN HYDROCHLORIDE

DEAR SIR,

Mianserin hydrochloride has recently been introduced as an antidepressant. Clinical studies have shown it to be an effective antidepressant (i.e. better than placebo, e.g. Murphy, 1975) and to be of about equal potency to standard treatments (e.g. amitriptyline—Coppen *et al*, 1976). The following case report provides some evidence on two further important features:

1. That mianserin may prevent relapses in recurrent depressive illness, and

2. Mianserin may be effective in some patients who fail to respond to other antidepressant therapy.

The patient was first seen three years ago (aged 24) when she gave a six-year history, which was confirmed by her general practitioner, of recurrent attacks of depressive illness which lasted a few weeks, resolved spontaneously but recurred. The illness appeared to be unaffected by diazepam or amitriptyline. Observation at psychiatric out-patients confirmed the patient's story. The patient suffered from a frequently recurring depressive psychosis, which was characterized by depression of mood, psychomotor retardation, pessimism, guilt and loss of sexual interest. Between attacks the patient was quite well. The episodes did not appear to be related to menstruation. The patient's treatment and response are shown in the accompanying table. For the first year

TABLE

Time	Treatment dose/day	Fraction of time depressed
0–1 year	Imipramine 100–150 mg	½
1–1½ year	Lithium carbonate 2,000 mg	0
1½–2 year	Lithium carbonate 1,000 mg	⅔
2–3 year	Mianserin 30–60 mg	0

the patient was treated with imipramine, receiving 150 mg per day for several months. She showed little or no response, being severely depressed for about half the time. For the second year, the imipramine was stopped and the patient received lithium carbonate. During the first six months of this year the patient received high doses (approximately 2,000 mg per day) to maintain therapeutic blood levels, during which time the patient suffered no attacks of depression. For the second six months of this year the dosage of lithium was reduced to approximately 1,000 mg per day because of lithium induced nausea. The plasma concentrations were then below therapeutic levels and the depressive episodes reappeared, the patient being severely depressed for about two-thirds of the time. For the third year lithium was stopped and the patient was