AUTHORS' REPLY: We are grateful to Dr Shah for his remarks about our paper. With regard to statistical tests employed, the χ^2 test was the appropriate statistic as the sample size was greater than 20. A Yates correction to the χ^2 is the correct statistic when the expected frequency of at least one of the cells is less than 5. There is disagreement among statisticians as to whether such a correction is necessary (Everitt, 1977), and on statistical advice we did not apply such a correction. However, even after applying such a correction, the results remain significant for the association between left basal ganglia calcification and delusions, and just fail to reach significance ($P<0.06$) for the right side. We admitted in the discussion that the number of patients involved is small, but this makes the trend of the association between delusions and basal ganglia calcification even more interesting.

With regard to Dr Shah's second point, his own unpublished figures are not comparable with ours since they are based on a hospital sample whereas our study included patients in a variety of settings. We agree fully that adequate drug trials, possibly using medication such as carbamazepine, are important for the treatment of aggression – a very troublesome and disruptive behaviour in Alzheimer's disease.

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Reference

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Oestrogen therapy for the menopause

SIR: Ballinger in her paper on psychiatric aspects of the menopause (*Journal*, June 1990, **156**, 773–787) comes to a clear conclusion that "anxiety and depression in such women do not respond to oestrogen therapy although some cases respond to antidepressants". Few endocrinologists and gynaecologists with a large experience in treating such women will agree with this dismissal of the value of oestrogens and we are sadly aware that there is virtually no meeting point between our specialties on this issue. This review article, quite devoid of objectivity and omitting most relevant publications during the last ten years, will reinforce traditional psychiatric prejudice on this subject.

"The gynaecological view" described by Dr Ballinger is a travesty which gives a biased view of what gynaecologists are meant to think. As one of us (JS) is singled out for particular scorn for "uncontrolled" statements, may we be permitted to bring to the attention of your readership some of the controlled studies of the value of oestrogens performed in this department and elsewhere that have been omitted by your author.

We would all agree that there is an excess of depression in women compared with men and that this excess begins from puberty and occurs more commonly at times of hormonal flux. This appears as pre-menstrual depression, post-natal depression and climacteric depression. Certainly these may also be times of greater stress and we accept much of the psychiatric emphasis on the environmental contribution to these peaks of psychiatric pathology but not to the exclusion of a hormonal component.

Dr Ballinger uses the term 'menopause' to describe the years around the time of cessation of periods. Although this is more precisely called the climacteric, it is acceptable in this context because of common usage and because, as she has stated, the literature suggests that any alleged increase in depression in these women occurs in the few years before the menopause. There is no clear evidence of an increased incidence of depression in women who are truly post-menopausal.

Depression in the 40-year-old woman with regular menstruation is frequently cyclical with attendant cyclical symptoms of loss of energy, loss of libido, bloated feelings, mastalgia and menstrual headaches. This combination of debilitating symptoms, best called the 'ovarian cycle syndrome', is common and gets worse with age until it becomes indistinguishable from the most distressing symptoms of the climacteric. The symptoms frequently lose their cyclicity, becoming more constant, but the similarity to those of the climacteric supports the view that the psychiatric symptoms of the latter are a continuum of those of the pre-menstrual syndrome. Oestrogens are effective in treating both conditions. The problem is that depression (although it may be cyclical) in the presence of regular periods is not considered by psychiatrists to be responsive to oestrogens.

Montgomery *et al* (1987) in a placebo-controlled study reported the beneficial effect of oestradiol implants on depression in a group of women attending our menopause clinic. However, this improvement in depression and anxiety was only seen in the pre-menopausal patients and not in those in whom periods had ceased. Data yet to be published show that this significant improvement in scores on the self-rating scale of distress (SRD-30) persists over