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SIR: I haven't encountered a barking patient, but I vividly recall one who mooed.

Again, like Dr Buchanan's patient it was a lady in late middle age who was admitted to hospital for assessment following her complaint that she was unable to control an urge to make a mooing noise during normal speech. I saw her as a trainee clinical psychologist, and found that she, too, exercised some voluntary control, but she asserted that she was unable to control the behaviour completely, since she was liable to moo in most embarrassing circumstances.

Unfortunately my training soon required me to move from this hospital, so I am unable to report the outcome of the assessment, or whether any treatment was effective.

If any other clinicians have encountered similar symptoms, might this represent a syndrome which could be called the MacDonald syndrome – or, in the senile, the Old MacDonald syndrome?

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SIR: A case was described recently in these columns of a patient whose principal symptom was barking. What is less well-known is that barking can be an effective form of therapy. I myself have used the technique on several occasions. The patient must be fully conscious, agitated, obstreperous, and canine. It would be interesting to know if psychoanalytical or behavioural explanations are more appropriate.

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## Screening for Hepatitis B in the Mentally Handicapped

SIR: The importance of screening for hepatitis B in both the hospital and community population of the mentally handicapped was pointed out by Jancar (*Journal*, September 1987, **151**, 417–418). As an infection control nurse, I recently compiled a study evaluating screening of patients before movement from hospital into the community, and further, to what degree vaccination is offered to patients and staff.

A questionnaire was sent to 25 Mental Handicap Units in the United Kingdom, with 76% response. The findings show that 37% of patients are not screened for hepatitis B markers, 37% are screened if in contact with a known carrier, 21% on admission, and only 5% of patients are screened before transfer into the community. It was established that vaccine was given to 32% of patients and 53% of staff having contact with a known carrier.

While only a selective sample, the study demonstrates that action is taken generally only in response to known carriers. Locally, screening for hepatitis B markers is considered a priority for those patients whose transfer into the community is imminent; moreover, a policy of screening all patients is in operation to enable preventative measures of infection control to be undertaken.

The financial implications of implementing this plan to screen and vaccinate patients and staff when appropriate are recognised. However, the recent reduction in cost of the hepatitis B vaccine should encourage a more appropriate response to this important issue.

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## Maternity Blues and Post-Partum Euphoria

SIR: I think Valerie Levy (*Journal*, September, 1987, **151**, 368–372) is right in maintaining that the maternity blues is related to the dysphoria which follows surgery and other stress, but she has omitted to mention an important psychological factor – post-partum euphoria. This, in my view, explains the difference between childbirth and surgery, and the gap between delivery and the onset of the blues.

The mood changes which follow hysterectomy have been studied by Kendell *et al* (1984) and Kennedy & Gath (1986): there is a steady fall from day one to day ten. Those following childbirth are similar from the fifth day onwards. The difference between the two is that depression scores are low during the first four days after delivery, rising sharply on the fifth day. These findings are compatible with a two-factor theory of the blues, which results from the combined effects of post-partum euphoria and post-traumatic dysphoria. In other words, the relief and joy which usually follow delivery protect against and mask the depression, tearfulness, irritability, and tiredness which would normally follow such an

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