Brit. J. Psychiat. (1980), **137**, 101–104

Correspondence

A BETA-ADRENERGIC STIMULANT IN DEPRESSION

Dear Sir,

I was interested in the report by Lecrubier *et al* in the *Journal* (April 1980, **136**, 354–8).

Our research group undertook a trial of another beta-adrenergic stimulant, orciprenaline (Wheatley, 1975), in which we were unable to demonstrate any antidepressant effect from that drug. However, we used oral administration and I note that the authors of the present paper resorted to intravenous infusion, because of the 'low bioavailability' of salbutamol by the oral route. Indeed, the authors comment that further research in this area may be difficult, as there is "no orally suitable drug . . . available to date".

Both salbutamol and orciprenaline are used, mainly by oral administration, by patients suffering from asthma, for which indication they are remarkably effective. One wonders therefore what differences there may be with regard to bioavailability, in the treatment of depression on the one hand and of asthma on the other. Possibly the explanation lies in the fact that orciprenaline (at least) would not appear to pass the blood brain barrier (Dengler, 1966), although in our study we postulated a possible peripheral action analagous to that of beta-adrenergic blocking drugs in anxiety states.

Perhaps the most encouraging aspect of the report was the rapidity of action of salbutamol, since the 'lag period' of 7–10 days with conventional antidepressant drugs is a serious drawback in clinical practice. However, the antidepressant action of the tricyclics at least may be accelerated by the addition of a small dose of triiodothyronine (Prange, 1968; Wheatley, 1972), which does seem to provide an alternative, although it has not been adopted into general therapeutic use.

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SEX DIFFERENCES IN THE SEASONALITY OF SCHIZOPHRENIC BIRTHS

Dear Sir,

Sex differences in the seasonality of schizophrenic births were noted by Dalen (1974) in South Africa and by Syme and Illingworth (1978) in Australia. To test for such differences in the northern hemisphere, data by sex were obtained for all schizophrenic patients born between 1927 and 1955, and admitted to the Missouri State Hospital system between 1962 and 1976, the total number analysed being 9,738 males and 7,513 females. As controls all births in Missouri by sex for the years 1927-1930 and 1942-1955 were used (data for 1931-1941 by sex are not available). Missouri has previously been shown to have a strong winter and spring predominance of schizophrenic births (Torrey *et al*, !977) and to have shifted from a winter predominance to a spring predominance between the 1920's, and the 1940's, (Torrey and Torrey, 1979).

Female schizophrenic births were compared with all female births and male schizophrenic births with all male births. The chi square with 1 d.f. was used to test for statistical significance. The results showed a seasonal pattern of schizophrenic births for both sexes which was very similar. January, February, March and May were the four months with the greatest excess of schizophrenic births for both sexes although the rank order differed (males: February, January, March, and May; females: January, May, February, and March). Analysis of the schizophrenic births by decade of birth and by sex also showed no major differences and no suggestion that the previously described shift was more a function of one sex.

We conclude that for the state of Missouri there is no evidence of any important sex differences in the

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seasonality of schizophrenic births. The causes of the seasonality, whatever they are, apparently affect male and female offspring in a similar manner.

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THE DISABILITIES OF CHRONIC SCHIZOPHRENIA

DEAR SIR,

I am full of admiration for the gargantuan efforts of Drs Owens and Johnstone in undertaking their study on 'The Disabilities of Chronic Schizophrenia . . .' (*Journal*, April 1980, **136,** 384–95). What is not made clear is whether the various assessments were made by one author or, if by both, whether independently or jointly. Although they had previously found the Withers and Hinton series of tests to be satisfactory they do not give information as to how successfully the Current Behavioural Schedule measures abnormal behaviour. While indicating that recorded information does not really allow separation of nuclear schizophrenia and schizophrenia without first rank symptoms they nevertheless give figures for the number of patients in each group and compare the frequency of negative schizophrenic features in the two types.

It was probably not feasible to arrange for an independent examiner to assess the neurological status of the subjects but this would have reassured readers that there was no bias towards finding abnormalities in keeping with the hypothesis that schizophrenia is a brain disease which produces multiple deficits. Likewise, neurological examination of a control series would have been helpful.

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DE CLERAMBAULT'S SYNDROME (EROTOMANIA) IN TANZANIA

DEAR SIR,

A 26-year-old single female Tanzanian was brought by her brother with the complaint that she was forcing herself on a man who was partially related to them (he had grown up with them as an adopted child). The passion had been sparked off at a brief encounter while she was with a boyfriend. She had dropped him in favour of the relative, whom she then pestered with visits and love-letters. She could not be stopped by his disavowals, discouragement and police intervention.

She was the youngest daughter of two girls and two sons. She was normal at school and worked as a bank clerk. Menstruation was normal. She was never keen on sexual intercourse, for fear of pregnancy.

Her father was originally promiscuous with numerous wives, but later became a fanatical Catholic. He sent his sons to be priests and the patient's sister became a nun. They all left these vocations, and the nun married, against parental threats, a man with numerous concubines and children. Other blood relatives are 'mediums', some are religious fanatics and aberrant personalities.

The patient had no ideas of reference nor hallucinations. She had no other sexual interest in men, but the intensity and incorrigibility of her infatuation never wavered. She remained impervious to psychological exploration and even with chemical abreactions revealed no emotion. Fluphenazine decanoate and fluspirilene gave her remissions, controlling the urge of pursuit, but not affecting the love object.

It is of interest that in certain Tanzanian tribes there are similar cases to this one with primary erotomania. I will report later on twelve I have observed myself. The natives realise that there is something odd about their behaviour and no marriage is formalized until after some ritual ceremonies have been performed.

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CHANGE IN A PSYCHIATRIC WARD

DEAR SIR,

Peter Kennedy *et al* (*Journal*, March 1980, **136,** 205–215) and especially the *Bulletin* (March 1980, 34–37) raises the management of change in a psychiatric ward. His ideas illustrate the insularity of psychiatry in relation to other disciplines, especially the behavioural sciences. He describes some degree of democratization of a ward social organization, but

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