

We are rather concerned that five of the patients kept in hospital over the Christmas period were there mainly because of the low levels of staffing of social services and community psychiatric services at Christmas. Although ideally everybody would like time off work to be with their families at this time of year, can the skeleton services provided currently be ethically justified in the light of the figures from our census?

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'Vital exhaustion' and myocardial infarction

SIR: Appels (*Journal*, April 1990, 156, 465–471) draws attention to the mental precursors of myocardial infarction. We would like to add the findings of our recent study of 50 Indian patients with acute myocardial infarction and 50 age- and sex-matched healthy controls. The frequency and intensity of type-A behaviour, life events occurring during the period of one year preceding myocardial infarction and the levels of anxiety and depression following myocardial infarction were studied.

According to Jenkins activity survey (form C; Jenkins *et al*, 1979), type-A behaviour was detected in 72% of patients as compared with 18% of the control group. With regard to different components of type-A behaviour, type A and factor S (measuring speed and impatience) were significantly higher in the study group, while factors J (measuring job involvement) and H (measuring hard driving and competitiveness) did not differ significantly between the two groups. The patients also had significantly greater mean frequency of stress scores on the Presumptive Stressful Life Events Scale (Singh *et al*, 1983) which measures both total life events and subgroups of this – the desirable, undesirable, personal, impersonal and ambiguous life events.

The stressful life events which discriminated the patients from controls were (in decreasing significance): marital conflicts, financial loss, change in working condition, major personal illness, trouble at work, death of a family member, and change/expansion of business. The mean scores of anxiety (as assessed by the Hamilton Rating Scale) and depression (as measured on Beck's Depression Inventory) showed statistically significant falls over the periods of two weeks, one month and three months after infarction, but became insignificant subsequently.

In conclusion, type-A behaviour and stressful life events are significantly associated with the risk of myocardial infarction.

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SIR: The 'vital exhaustion' preceding myocardial infarction in men discussed by Appels (*Journal*, April 1990, 156, 465–471) is supported by a correlation of type B with somatic risk factors of coronary heart disease in adolescent boys (Keltikangas-Jarvinen & Jokinen, 1989). It is also supported by speech hesitation pauses of one second or more occurring more than twice a minute, a component of type-B style but not of global type-A, predicting a six-fold increase in coronary incidence in two groups of normal coronary-prone men followed prospectively for ten years (Case *et al*, 1988). The correlation of the 'traditional' type-A components like impatience and sense of hurry with somatic risk factors of coronary heart disease in adolescent girls (Keltikangas-Jarvinen & Jokinen, 1989) may have been due to their higher metabolic rate (Baxter *et al*, 1988) and dopamine lateralised to the right hemisphere (Friedman; *Journal*, February 1990, 156, 285). The role of gender-related hemispheric differences is supported by increased dopaminergic activity manifested by mania in a 76-year-old woman with improved Parkinsonism (Menza & Chastka, 1989) compared with reduction of obsessive slowness in a 17-year-old boy in response to fluoxetine, with a return to normality of decreased tracer deposition in the right basal ganglia and adjacent temporal lobe (Hamlin *et al*, 1989).

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