four months after discharge, despite radioiodine and carbimazole. Further ^{131}I treatment rendered him hypothyroid, and thyroxine replacement was started. He also remained diabetic. There was no family history of endocrine disorder. Since commencing lithium he had noticed a marked improvement in his psoriasis. The skin lesions had gone and his nails had lost any sign of involvement. He is currently well, remains euthyroid, and has suffered no major mood swings for ten years. He is maintained on lithium (1250 mg/day), doxepin (50 mg nocte) and insulin (twice daily). He is free of any signs of psoriasis.

Reversible hyopothyroidism with lithium is well known (Schou *et al*, 1968). Hyperthyroidism complicating lithium therapy is rare, and the relationship between the two is unclear (Rosser, 1976). Hullin (1980) reviewed thirteen cases, of which most had other contributory factors.

The action of lithium on carbohydrate metabolism is complicated and there is conflicting evidence, some reports indicating increased glucose tolerance and others suggesting the opposite. The mixed metabolic and hormonal effects of lithium on glucose utilisation and the unknown effect of manic depressive illness itself on glucose homeostasis may account for this. Diabetes in long-term lithium therapy is known, but has occurred mainly in those previously predisposed. Glycosuria and impaired glucose tolerance are recognised in relation to thyrotoxicosis, but their persistence is unusual.

Treatment with lithium compounds is known to predispose to the development or exacerbation of psoriasis (Carter, 1972: Skoven & Thormann, 1979). We know of no other reported case or remission of psoriasis during treatment with lithium, and although the relationship of skin diseases in general to emotional disturbance is vague and ill-defined, the resolution, particularly of severe nail changes, correlated very closely with the onset of treatment with lithium.

M. S. HUMPHREYS
J. L. WADDELL

Herdmanflat Hospital
Haddington
East Lothian

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Disulfiram reaction during sexual intercourse

SIR: A 44-year-old woman who had been taking disulfiram (200 mg daily) for 2 months reported vaginal stinging and soreness during intercourse. Her husband experienced similar discomfort to his penis. This occurred only when her husband had consumed large amounts of alcohol within the preceding 12 hours. The reaction was less noticeable when she took 100 mg disulfiram daily, and when her husband was less intoxicated. A disulfiram-alcohol interaction may occur locally in some patients. Have other clinicians heard reports of this effect?

J. D. CHICK

Alcohol Problems Clinic
Royal Edinburgh Hospital
35 Morningside Park
Edinburgh EH10 5HD

Prasad's Syndrome

SIR: Prasad (1985) was the first to describe the manic presentation of Hashimoto's thyroiditis in a lady who had repeatedly failed to respond to all forms of conventional antipsychotic therapy. Once her condition was diagnosed, after detection of an increased antithyroid antibody titre and RAI uptake and the thyroid replacement treatment commenced, her psychiatric symptoms resolved.

Although manic presentation of other thyroid abnormalities have been reported, this was the first report of its kind in Hashimoto's disease, which led the author to conclude that a thorough thyroid screen may be useful in the differential diagnosis of 'resistant mania'.

Case reports: (i) A 50-year-old housewife was brought to the psychiatric out-patient clinic in a hyperactive state. Her speech was markedly pressured and she was expressing flight of ideas. According to her husband, she had been functioning normally until about a week prior to her referral when she started staying awake the whole night. Her behaviour steadily worsened and became unmanageable. She had no past history of psychiatric consultation and no family history of psychiatric illness. She was admitted to the psychiatric ward and commenced on haloperidol in increasing doses of up to 60 mg/day, when she started showing mild extrapyramidal side-effects. She remained on this dose for 6 weeks without any change in her mental state. Addition of lithium carbonate in doses of 200 mg b.d., with serum level of 0.6 mEq/l, did not bring about any change. At this stage, a comprehensive physical work-up revealed antithyroid antibody titre. She was commenced on thyroid replacement therapy. Her mental state improved rapidly and she has remained symptom-free for the past 6 months.

(ii) A 36-year-old divorced office secretary was brought to the psychiatric out-patient clinic following a referral from

her doctor. She had been known to be healthy until about 10 days prior to her referral, when her colleagues noted her to be unusual. She became disinhibited and started making sexual suggestions. Later on, she began singing at the top of her voice and completely neglected her work. One of her friends at work took her to see her own doctor which ultimately led to her referral. There was no previous history of psychiatric contact, nor was there a positive family history. She was admitted to hospital and prescribed chlorpromazine in increasing doses up to 1500 mg, when she started showing anticholinergic side-effects. She remained on this dose for 5 weeks without any change in her mental state. A thorough physical screen revealed antithyroid antibody titre. She was commenced on thyroid replacement therapy. A week later her symptoms had disappeared, and she remained symptom-free three months later.

Both these patients had an acute onset in a healthy premorbid personality. They remained resistant to high doses of antipsychotics drugs, but responded rapidly to thyroid replacement therapy. They lend further weight to Prasad's contention that resistant mania in a good premorbid personality merits investigation for Hashimoto's thyroiditis.

M. J. WEINER
C. KENNEDY

Whipps Cross Hospital
London E11 1NR

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"Criminal Law and Psychiatry"

SIR: May I please comment briefly on Dr Paul Bowden's review of *Criminal Law and Psychiatry* (*Journal*, October 1987, **151**, 573–574).

I appreciate the need for criticism and welcome it, but cannot help feeling that this review does less than justice to the work of my distinguished co-author. The tone is personal, the judgments subjective and shallow and, regrettably, where it is specific, it takes passages out of context and summarises them inaccurately.

This was not so much a criticism of a serious book as an attack on its authors. I understand why Consultant Forensic Psychiatrists and Senior Prison Medical Officers do not always see things from the same perspective, but I think it is rather sad that this should colour the judgement of such a distinguished man.

We refute the allegations of professional error and will continue to be unrepentant bureaucrats. We know that necessary bureaucracy is inescapable if criminal courts are to function, if the Mental Health Act 1983 is to be properly applied with all its safeguards, and if penal institutions and special hospitals are to operate within the law.

D. H. D. SELWOOD

Brigadier Legal
HQ BAOR
BFPO 140

A HUNDRED YEARS AGO

Escape of a hospital patient

The following authoritative particulars respecting the escape of an in-patient from Guy's Hospital, and his subsequent death, will be interesting, since the case has been the subject of a good deal of publicity. The deceased was admitted to the hospital on Tuesday fortnight, suffering from a poisoned hand. He got worse, and on Wednesday was removed to the strong room, where he was strapped down, under the care of a probationary nurse. He showed symptoms of mental aberration from the time of his admission, the most marked being his determination not to partake of food, which had to be administered through the nostrils and by the rectum. Being quiet and apparently manageable, the house-surgeon, on Thursday morning, perhaps unwisely, released one of his hands, with which he soon undid the other fastenings as soon as the house-surgeon left the room. It appears that it was during the interval in which the house-surgeon went to another ward to get a police-constable, who was watching a criminal case, to relieve the nurse, that the man made his escape. Help could have been instantly obtained from the ward above, had the nurse understood the working of the speaking tube; and after a struggle with the nurse, the patient escaped in a state of nudity into the street. Going to a police station, he appears to have told the police that he had escaped from a back room at the hospital, where some men had been trying to murder him. He was ultimately brought back to the hospital, where he died from cellulitis of the chest-walls and septicaemia. It came out in evidence that the man was not injured in any way by his escapade.

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