of stay was six weeks. Thirty-five patients were over 60 years of age; two-thirds were male. Of the 57 amputations, 45 had been performed because of vascular disease; only 5 were the result of trauma. Thirty-two patients had previously undergone at least one vascular surgical procedure.

On assessment of anxiety and depression, using the DSSI-SAD questionnaire (Bedford and Foulds, 1978) 14 of the 22 patients questioned scored zero in the anxiety section, and only 1 patient had a score suggesting significant abnormality. For the same group, the corresponding figires for the depression section were 15 and 2. The use of antidepressants and hypnotics was minimal. On admission, 34 patients used a hypnotic regularly, this figure falling to 14 by the time of discharge.

Despite this being an elderly population, there was little abnormality in mental state as detected by the Isaacs-Walkey Mental Impairment Measurement questionnaire: of the 45 patients tested, 43 showed no significant mental impairment. On admission 9 patients complained of phantom limb pain, and 6 patients still had these sensations at discharge.

These preliminary results, with further studies in prospect, indicate that the level of psychiatric morbidity in this group of elderly non-traumatic amputees is considerably less than that reported by Shukla for young traumatic amputees. There was little evidence of the grief and bereavement reactions traditionally expected in such patients due to their symbolic loss, and phantom pain was only a minor problem. Indeed a commonly expressed emotion after the amputation was relief at the eventual loss of the source of prolonged severe pain.

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ECT IN AN INDIAN RURAL TEACHING HOSPITAL

DEAR SIR,

The impression given by the author of the paper with the above title (*Journal* 1981, **139**, 569–71) is that ECT is quite popular in India, and he advocates using it in schizophrenia. While agreeing with his views on its use on economic grounds only, I would like to clarify the prevailing circumstances in India vis-à-vis ECT.

India is a developing country and the majority of the population is poor. For the very poorest, perhaps ECT has to be resorted to since they cannot afford to buy drugs, and the hospitals are not in a position to supply them free, but for the patients with a slightly higher income there is no reason to believe that ECT is frequently used. ECT is rather more popular with psychiatrists engaged in private practice because this brings more financial benefit to them than prescribing drugs only. In fact these practitioners have projected an image as if ECT is invariably the treatment of any psychiatric illness. The superiority of neuroleptics over ECT in the management of schizophrenia is well known and needs no further elaboration.

This is not to deny the value of ECT in selected cases with specific indications, particularly those rare patients who are not responsive to neuroleptic drugs. Nevertheless, the convenience of cheapness, or expense, must be distinguished from therapeutic effectiveness.

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EPIDEMIC PSYCHOSIS

DEAR SIR,

Harrington has recently described three outbreaks of epidemic psychosis occurring in Thailand (*Journal*, 1982, **141**, 98–9). A similar interesting case occurred in Malta two years ago. Unfortunately I was unable to investigate the case personally at the time, and my report is based on local press reports and some second-hand descriptions from relatives.

On the 21st of June 1980 at eight o'clock in the morning, a group of children between the ages of ten and twelve together with their teacher were waiting by the sea-front for the school bus. The children were midway through their end of year examinations, and were possibly under some stress. Suddenly several of the children appeared very agitated and claimed that they could see the figure of a woman dressed in white gliding slowly out of some disused buildings and over the sea, disappearing shortly afterwards. Some of the children also said that she was carrying a dog under each arm. The teacher who was with them saw nothing.

Two hours later, at a different school, another group of children also claimed to see this figure at their school. Several hours later, well after sundown, three fishermen who were out fishing were shocked to see the ghostly figure of a nun dressed in white glide past them over the water. They were taken to the local hospital casualty, and were said to be suffering from shock. The following day there were isolated reports of the nun being seen at various places, including the airport.

As the stories spread, people crowded at places where sightings had been reported, several of them

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taking their cameras. People living in the vicinity reported that June 21st, 1980 was the anniversary of the death of a nun who had suffered a heart-attack nearby. After the first few days no further sightings were reported.

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IDENTICAL TRIPLETS: NON-IDENTICAL PSYCHOSIS?

DEAR SIR,

I have managed to subscribe to the Journal from this year for our hospital and I am able to make good use of it in postgraduate training.

May I comment on the article entitled: "Identical Triplets: Non-Identical Psychoses?" in the January issue (**140**, 1–6). In my opinion, the genetical conclusions that follow from the article may be too hasty. Despite the carefully considered diagnosis by a number of specialists, it does not appear entirely beyond doubt that the triplets had different forms of illness. It will be recalled that two of the triplets were schizophrenics, more precisely, their illness was diagnosed as schizoaffective psychosis and the third as manic-depressive psychosis. As a practising psychiatrist, I was bothered by the fact that an earlier schizoaffective episode had been recorded in the manic patient. However, one of the three persons examining the patients also diagnosed another patient (referred to in the article as M) as a manic-depressive. After reading the brief histories of illness, I consider that there is a possibility that all three of the patients may be suffering from schizoaffective psychosis.

I considered it important to mention the above, since the danger could arise not only of losing the possibility of making finer distinctions within schizophrenia, but also of blurring even the Kraepelin dichotomy. The article thus leads to a fundamental problem and was therefore highly thought-provoking.

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DEAR SIR,

We do not disagree with Dr Keleman that all 3 of the triplets may have "schizo-affective psychosis", in that they seem to have a form of illness which cannot be readily classified as either dementia praecox or manic depressive insanity in the classical Kraepelian sense. They are definitely genetically identical and it therefore seems inescapable that they all have the same illness despite certain dissimilarities at the clinical/phenotypic level.

We reported them to illustrate that in some instances the Kraepelian paradigm is inadequate and that patterns of psychopathology or course of illness do not infallibly reflect underlying genetic or biological substrate. We concluded in our paper that it is probable that "the area between Kraepelin's two entities is not unoccupied territory", but far from wishing to blur the distinctions within the Kraepelin system, as Dr Keleman fears, we are greatly in favour of refining present nosological systems. However, we believe that progress in this field is more likely to occur if attention is paid to biological correlates and to familial aggregation of particular symptom clusters. We have no axe to grind either in favour of the notion of a continuum of psychoses, with typical schizophrenia at one end and typical manic depressive illness at the other, or in favour of the separate existence of a third entity. However, we do consider that if psychiatric nosology is to avoid becoming a degenerate science (Urbach, 1974), then apparently anomalous cases such as the 'Z' triplets compel a fundamental re-examination of classificatory systems, rather than ad hoc adaptions of the existing orthodox schema.

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