persistent diurnal depressive mood state developed, and she was admitted to a psychiatric hospital. No physical or psychological explanation of her symptoms could be discovered, and she had no previous psychiatric history. By this time she had continued to take this same dose of cimetidine for six months. Reduction of cimetidine to 200 mgs b.d. produced some improvement in her symptoms, and two weeks after total discontinuation of cimetidine, all her psychiatric symptoms had completely disappeared and have not recurred.

Anxiety-depressive syndromes as a complication of cimetidine therapy are clearly of importance to the psychiatrist, particularly as the frequency of their occurrence is as yet unknown. This complication may also have relevance to recent studies of the biological basis of endogenous depression, where disturbances of histaminergic neurones have been thought to be aetiological. (Leader, Lancet, April 15, 1978).

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NECROPHILIA, MURDER AND HIGH INTELLIGENCE

DEAR SIR,

The case report concerning 'Necrophilia, Murder and High Intelligence' by N. P. Lancaster (*Journal*, June 1978, **132**, 605–8) is of great interest. Not the least aspect of interest is the comment that 'He disliked dead bodies and whilst nursing was stated to have tried to get others to lay out the dead. He had eventually left nursing because of his dislike of nursing old people'. This in a man who 'Apart from the murder and the two mortuary incidents (involving female corpses), (he) was not sexually perverted'.

Clearly the patient/prisoner has gross sexual psychopathology and this we suggest is indicated by his nursing history. In an article we have published, 'Homosexual Necrophilia' (Bartholomew *et al*, 1978) we quote from a review of the literature by Bierman (1962). In this review he states: 'Glauber (1953) showed how necrophilic fantasies may act as a deterrent to the study of medicine. Pomer (1959) demonstrated how necrophilic fantasies similarly contributed to a work inhibition in a pathologist'. The article by Pomer is entitled 'On Necrophilic Fantasies and Choice of Specialty in Medicine'. This raises some interesting speculations not only in terms of the whole of medicine but in the smaller field of psychiatric medicine. For example, do the four groups of psychiatric consultants delineated by Hafner, Lieberman and Crisp (1977) have significantly different (sexual) psychopathology which significantly determines the area of sub-specialization, e.g., geriatric or child psychiatry, and the therapeutic techniques practised, e.g., electro-convulsive or psychotherapy.

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DEAR SIR,

It appears that the outcome of Dr Lancaster's case (*Journal*, June 1978, **132**, 605–8) has satisfied neither him nor subsequent correspondents. Judging by his paper, a plea of diminished responsibility on the grounds of psychopathic disorder would be unacceptable to Dr Lancaster, and that his case had suffered from a confusional state or non-insane automatism was unacceptable to the prosecution psychiatrists (and the jury). Manslaughter on the grounds that the accused was unable to form intent might or might not have been successful, yet it must be remembered that unlike *Beard* or Dr Pierce James' example (*Journal*, January 1979, **134**, 125), Dr Lancaster's case remembered not only what he had done but also being aware of doing it at the time.

His description would probably be given the diagnosis of pathological intoxication by the early authors described by Banay (1944), which encompasses the symptoms Dr Fullerton (*Journal*, October

1978, **133,** 382) felt consistent with a diagnosis of temporal lobe epilepsy, and which falls under Article 11 of the *Fundamentals of Criminal Legislation of the USSR* classified as a temporary mental disorder, the diagnosis made along the lines described by Rozhnov (1970). However, Hunter Gillies (1965) describes how in his experience 'psychiatric explanations of this type were poorly received by the courts'. Caplan (Hobson, 1962) suggested that such an explanation would be acceptable to lawyers, but the problem is knowing 'where the disease begins and where it has not yet begun'. Similarly, there is no way at the present time of providing acceptable objective evidence, required by this country's lawyers, that such a condition has ever existed in an individual.

Dr Pierce James' letter is important in raising the issue of pleading manslaughter when it can be shown that the accused did not possess the ability to form an intent to murder, as there appears to be a grey area between simple drunkenness, which is no defence to murder, and a McNaughton verdict. One must symphathize with the position of a defence psychiatrist on such a case in his difficulty to demonstrate that a confusional state or non-insane automatism had existed in the patient, or to make the uncertain attempt to base a plea of manslaughter on points of law.

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[This correspondence is now closed—*Editor*]

SELF-REPORT OF SLEEP DEPRIVATION THERAPY

DEAR SIR,

This 46-year-old lady had suffered phases of alteration of mood for 20 years, but for the last five years had been consistently depressed between September and March, with marked lethargy and despair in the mornings, frequent wakening during the night, and a loss of appetite. Each depressive phase had been preceded by a week of elation, accompanied by unusual physical exertion and loud singing around the house. She had been admitted to hospital and treated with imipramine during a previous phase, without marked alteration in the time course of the mood changes. Her premorbid personality was cyclothymic and obsessional, and she had had a sister with similar phasic changes treated as an in-patient.

Even in a depressed phase, she continued to work two nights a week on Friday and Saturday, and her husband remarked that she was back to normal on returning home at 8 a.m., though this was normally her worst time of day. However, after making up her sleep on Sunday night, she once more awoke depressed on Monday morning.

This short-lived lifting of depressed mood is the same as that described by Bhanji and Roy (*Journal*, 1975, **127,** 222–6), whose work was quite unknown to both the patient and her husband.

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NO LUNG CANCER IN SCHIZOPHRENICS?

DEAR SIR,

I was much intrigued by the observation of Dr David Rice (*Journal*, January 1979, **134,** 128) that he cannot recall a single case of a chronic schizophrenic patient dying of bronchial carcinoma. However, the same extraordinary low incidence of bronchial carcinoma is to be found in the long stay subnormality hospitals. I have for some years been concerned about the number of patients not receiving an adequacy of pocket money where the long stay hospitals have been so poor that the management have not felt themselves able to give patients the amount of money laid down as standard by the Department. (This problem has now, of course, been largely eliminated since the introduction of NCIP). In trying to convey my anxieties to my colleagues in an arresting fashion, I have used the flippant phrase, 'In 20 years of hospital psychiatry, I have never had a patient rich enough to get bronchial carcinoma'. To smoke 40 factory-made cigarettes a day would cost a patient £7 per week.

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