

as hybridisation probes, RFLP patterns can be detected which correlate with known HLA-DR-specificities. As devised by Cox *et al* (1988), identification of most specificities is possible by analysis of RFLP patterns obtained after digestion of genomic DNA with the restriction endonuclease TaqI. There are only two exceptions: DR3 cannot be distinguished from DRw6, nor DR7 from DRw9 by this procedure.

In order to re-examine the hypothesis of a possible association of HLA-DR2 to affective disorders in a larger sample, we investigated 88 patients (53 females, 35 males) diagnosed according to DSM-III criteria (American Psychiatric Association, 1980). Fifty-seven of the patients had bipolar illness and 31 had major depression. Thirty-two showed a family history of affective disorders. Age-of-onset ranged from 14 to 64 years.

One hundred people recruited from medical students and medical and laboratory staff served as control probands, and those who had first-degree relatives with affective disorders or a personal history of psychiatric illness were excluded from the study. The female:male ratio was 51:49. All the subjects tested were Caucasians of European origin. The laboratory procedures followed standard protocols.

In our sample of patients with affective disorder, HLA-DR2 is less frequent (8%) than in healthy control probands (16%). The other DR-specificities were not different between patients and controls. Calculation of a 2×2 χ^2 statistic for the frequencies of HLA-DR2 in patients and controls even reaches borderline statistical significance ($\chi^2 = 4.245$; $P = 0.039$) without correction for multiple testing.

Obviously, our results do not confirm those found by Riemann *et al*. Since population association studies are well known to be affected by stratification effects, we would not claim a negative association of DR2 to affective disorders. In any case, we could not replicate the reported association of HLA-DR2 to affective disorders.

Acknowledgements

JK is a recipient of a fellowship of Northrhine-Westphalia. We thank Professor Bernard Mach, Geneva, for kindly providing us with the DR β -probe.

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Clomipramine for OCD

SIR: The points raised by Chiu *et al* (*Journal*, January 1990, **156**, 112-115) that clomipramine may be useful in treating delusions, and that there may be an association between monosymptomatic delusional states and obsessive-compulsive disorder (OCD), possibly involving an underlying abnormality in serotonin function, are not new.

Over the past few years ideas concerning the identity of OCD have been changing. Treatment studies in OCD, which consistently demonstrate a selective response to drugs with 5-hydroxytryptamine-(5-HT)-reuptake inhibitor properties and a failure to respond to other conventional antidepressants, anxiolytics and antipsychotic drugs (Montgomery *et al*, in press) suggest a distinct, principally serotonergic abnormality underlying the illness, and an identity separate from the anxiety disorders (with which OCD is currently classified in international diagnostic systems), from depression and from schizophrenia.

Phenomenological studies of OCD also indicate that some of the traditionally-accepted diagnostic criteria - notably the need to resist and to be constantly aware of the senselessness of the symptoms - may not be as important as previously thought. Patients who have been suffering with chronic obsessions and compulsions for many years often, understandably, lose the urge to resist (Stern & Cobb, 1978). The need for complete insight into the absurdity of the phenomena remains a rather more controversial subject. Again, patients with long-standing severe OCD may, at times, appear to fail to recognise the senselessness of their behaviour, while, at other times, may retain complete insight. Insel & Akiskal (1986) review a number of individual cases of OCD where a shift from 'obsessions' to 'delusions' was monitored as the illness became more severe and insight was lost. Interestingly, these 'deluded' patients still responded best to treatment with clomipramine.

The recent open reports of five cases of body dysmorphic disorder (DSM-III-R), where ideas about body deformities bordered upon the delusional in the absence of prominent depression, and where the patients responded to treatment with 5-HT-reuptake inhibitors in preference to a variety of other antidepressants and neuroleptics, are consistent with the proposal of a common serotonergic pathology underlying some monosymptomatic delusional disorders and OCD (Hollander *et al*, 1989). Depressive symptoms commonly occur as part of OCD, and the concept of OCD as a syndrome composed of a spectrum of symptoms including delusions has gained some recognition (Solyom *et al*, 1985).

However, open reports of drug responses are notoriously unreliable and it is a pity that Dr Chiu's cases also fall into this category.

Controlled investigation of non-depressed individuals with monodelusional states, examining the efficacy of 5-HT-reuptake inhibitors and neuroleptics, either alone or combined, are indicated to explore OCD and delusions more thoroughly.

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Unmet needs for medical care

SIR: Brugha *et al* propose a potentially useful concept in their paper on unmet needs for medical care in the long-term mentally ill (*Journal*, December 1989, **155**, 777-781). However, because of suspect methodology and inadequate evidence (at least as reported in the paper) it is impossible to accept their conclusions.

Firstly, in a paper discussing physical health and illness, it is difficult to understand the rationale behind not performing a physical examination on

each patient. The authors acknowledge this, but do not attempt to explain it. Nevertheless, they claim the presence of dental or gum disease in 28% of those "who were examined".

Secondly, the authors make two quite unsubstantiated claims regarding the particular value of thyroid and liver-function tests and the finding that need for medical care was equally likely in users of non-hospital day services. They are obvious important implications for both these claims, but it is impossible to judge their merits without being able to examine the evidence underlying them.

The final, and perhaps most glaring omission, is the absence of any reference to the primary health care services. It seems highly likely that the level of unmet need for medical care in a defined population is highly dependent on the local primary care services. The knowledge, concern and skills of the primary care team, together with the liaison between the primary and mental health care teams, particularly regarding responsibility for the physical care of these patients, will surely influence the levels of unmet need in the population.

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Glucose metabolic rate in schizophrenia

SIR: A decrease in the glucose metabolic rate in the right frontal lobe in schizophrenics compared with controls (assessed by positron emission tomography during a continuous performance test) (*Journal*, February 1990, **156**, 216-227), and a significant reduction of mixed- and left-handedness in male epileptics with schizophrenia (*Journal*, February 1990, **156**, 228-230) suggest a protective role for lateralised brain function. This is supported by norepinephrine-induced exacerbation of schizophrenia (van Kammen *et al*, 1990), manifested by auditory hallucinosis during oculogyric crises (*Journal*, July 1989, **155**, 110-113 and October 1989, **155**, 569-570), which may be elicited by noradrenergic-mediated inhibition of dopamine lateralised to the right hemisphere (Rascoll *et al*, 1989 and *Journal*, February 1990, **156**, 285). In contrast, compulsions were characterised by prolonged spin-lattice relaxation time on magnetic resonance imaging in the right frontal cortex (Garber *et al*, 1989), and auditory-visual hallucinations preceding oculogyric crises were perhaps induced by fatigue in a non-schizophrenic epileptic woman (Leigh *et al*, 1987).