

Obstetric liaison

SIR: The article by Appleby *et al* (*Journal*, April 1989, **154**, 510–515) was interesting to all those attempting to provide a liaison service in a general hospital with an obstetric unit. However, I was concerned that they had not received any referrals for women who had experienced miscarriages or stillbirths.

Recently I have seen two cases of women presenting as parasuicides less than a week after a miscarriage. At the time of their miscarriage they were not given any supportive counselling by nursing or medical staff, and they were expected to 'carry on as normal' after the event. This they were clearly unable to do.

I think it would be worthwhile providing training for medical staff and midwives so that they may be able to help these women in order to alleviate further psychiatric difficulties.

GABRIELLE MILNER

Walsgrave Hospital
Clifford Bridge Road
Walsgrave
Coventry CV2 2DX

Calcium techniques

SIR: Patel *et al* (*Journal*, December 1988, **154**, 849) point out additional factors for consideration in further studies of the relationship between calcium and extrapyramidal symptoms. They do not mention desirable scientific requirements of calcium assays, nor indicate whether their own collection and assay techniques involved standardisation or correction.

Firstly, the length of venostasis has a critical effect on measured serum calcium levels, for which omission of a tourniquet achieves consistency (Zilva & Pannall, 1981). Secondly, it is well recognised that ionised calcium (Ca^{2+}), rather than the total serum calcium, represents the biologically active fraction. While albumin-adjusted calcium (or corrected calcium) corresponds closely to Ca^{2+} (Larrison & Ohman, 1978), technology now permits the direct measurement of ionised calcium (Bowers *et al*, 1986).

Consideration of these factors should strengthen the interpretation of further research in this area.

MARCELLINO G. SMYTH

All Birmingham Rotational Training Scheme
Charles Brown Clinic
Queensbridge Road
Moseley
Birmingham B13 8QD

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Neuroleptic malignant syndrome

SIR: Goldwasser *et al* (*Journal*, January 1989, **154**, 102–104) discuss the major difficulty of how to manage acute psychiatric disturbance in those concomitantly suffering from neuroleptic malignant syndrome (NMS). Their contribution to this subject is timely. However, I would like to make two points.

They state that they believe that their two cases are the first reported where definite NMS existed and terminated while the patient was still being treated with antipsychotic drugs. I reported a case in the *Journal* (McCarthy *et al*, 1988) of a similar occurrence, and these new cases represent interesting support for our conclusions in that paper.

Dr Goldwasser *et al* also discuss the value of creatinine phosphokinase measurements (CPK) in these patients. Although of definite value, there are limitations to the usefulness of these measurements. It is important to note that CPK may not be elevated at all in some cases of definite NMS (Levenson, 1985), or may only be elevated at a late stage of the illness. An elevation of CPK can also occur for many other reasons, e.g. after intramuscular injections. A measurement of CPK should therefore be only one of the criteria for the diagnosis and management of NMS.

ANTHONY MCCARTHY

Department of Psychiatry
Guy's Hospital
St Thomas Street
London SE1 9RT

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NMS and thioxanthenes

SIR: I am a little perplexed by the claim of Kemperman (*Journal*, April 1989, **154**, 562–563) that the equal D1 and D2 receptor binding characteristics of the thioxanthenes may be responsible for the low

prevalence of malignant neuroleptic syndrome with this class of drugs. Although an equal binding pattern to D1 and D2 receptors has been demonstrated *in vitro*, to my knowledge the *in vivo* research using PET scan technology has shown preferential binding to D2 type receptors with only 20% to 25% D1 receptor occupancy (Farde *et al.*, 1988).

CLIVE BALLARD

*Walsgrave Hospital
Clifford Bridge Road
Walsgrave
Coventry CV2 2DX*

Reference

FARDE, L., WIESEL, F. A. & HALLDIN, C. (1988) Central dopamine receptor occupying in schizophrenia. *Archives of General Psychiatry*, **45**, 71–78.

Schizophrenia, season of birth, and maternal age

SIR: Dalen (*Journal*, December 1988, **153**, 727–733) demonstrates, with British and Swedish data, increased seasonal variation of births associated with raised maternal age. He thus provides a possible explanation for the season of birth effect in schizophrenia, given the previous observations that maternal age at birth is raised in samples of schizophrenic patients. In addition, he suggests that the observed excess of births by older women in the early months of the year is due to age-related decline in their fertility. The essence of this argument is that a cohort of such women will be older, and hence less fertile, in the later part as compared to the earlier part of the year. Although true, this is concerned with a cohort, not an age class, and is therefore not directly relevant. His example of a cohort of women born in 1935, who will be in the age class 15–19 from 1951 to 1954, demonstrates an apparent seasonal effect only because the time interval considered begins at the beginning of one year and ends at the end of another year. However, the arbitrary convention that January is the first month of the year is irrelevant to age calculations, and more appropriate time intervals to consider would be those which begin on the 15th birthdays and end on the 20th birthdays of the cohort. These time intervals are precisely when the cohort will be in the age class 15 to 19, but can begin and end at any time of the year. When a time interval begins at the beginning of one year, and ends at the end of another year, then the rising fertility in this age-range results in an excess of births in the later months of the year. However, when a time interval begins in the middle of one year, and ends in the middle of another year, the rising fertility produces the opposite effect – an excess of births in the earlier months of the year.

Considering the entire cohort, there will not be an obvious overall seasonal effect.

The increased seasonality of birth associated with raised maternal age is probably related to the decline in fertility in a different way. Consider fertility to be composed of two additive components: the first representing the level of fertility, which is relatively stable but changes with age; and the second representing the superimposed fluctuations which occur regularly at one cycle per year. The ratio of the amplitude of the seasonal fluctuations to the level of fertility will then be a determinant of the apparent magnitude of the seasonal variations of births. It is possible that this ratio increases as fertility level falls with advancing age, and results in the increased seasonal variation of births in the older age groups as demonstrated by Dr Dalen. This explanation does not have the difficulty raised by Dr Dalen with his argument that southern hemisphere studies of schizophrenia show an excess of births which is not at the beginning of the year.

PAK SHAM

*Genetics Section
Institute of Psychiatry
Denmark Hill
London SE5 8AF*

Homosexual erotomania

SIR: We were interested to read Dunlop's account (*Journal*, December 1988, **153**, 830–833) of two cases of female homosexual erotomania. This has been reported before (Lovett Doust & Christie, 1978; Signer & Cummings, 1987).

Dr Dunlop equates erotomania with de Clérambault's syndrome, but we feel that her cases do not meet the criteria for de Clérambault's syndrome. De Clérambault formulated the 'fundamental postulate' which describes the essential characteristics of the condition: the conviction within the patient (the subject) of being in amorous communication with a person of higher social status (the object), who has been the first to fall in love and the first to make advances (Enoch & Trethowan, 1979). Neither of Dr Dunlop's cases appear to hold the delusional belief that the other person (in both cases another woman) is in love with her. Her first patient's love object "approached her first, expressing concern and wishing to be helpful". There is no evidence that the patient believed the object to have had any amorous interest in her. Her second patient experienced the abrupt onset of "something special" between herself and the object and developed an obsessional attachment to her. She hinted at "more than platonic" feelings for the object, but no mention is made of belief in reciprocation by the object.