

to her menses. She had two mild episodes of depression lasting some months and requiring chemotherapy. Her work record has not been as good as it was pre-accident. She terminated her engagement and has had some contact with new boyfriends, but no lasting relationship.

Her legal advisors requested some indication of the prognosis for mania following head injury or road traffic accidents. A search of the literature failed to reveal hard facts upon which to base the medico-legal report. This was surprising in view of the amount of literature available on depression and head injury. I would be grateful, therefore, if your readers could either through your columns or by direct correspondence acquaint me with a prognosis of the cases of mania following road traffic accidents of which they have had knowledge and experience.

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INFORMED CONSENT—OR THE UNWITTING PARTICIPANT

DEAR SIR,

In his paper on informed consent (*Journal*, October 1983, 143, 416–8) Max Hamilton states that it is a product of the anti-medicine movement, comprising material that patients mostly don't understand, so here "the nonsense enters". And "if it is meaningless in the clinical situation, it is equally so in a clinical trial". In summary, he is no advocate of it. However, there is another side of the medal that he did not discuss.

First, evidence before a court, followed by a lengthy discussion in the *Lancet* in 1982, showed the necessity of obtaining informed consent. Professor Hamilton must have overlooked this discussion. It concerned the death of a 84-year old widow following bone marrow suppression induced by 5-FU after an operation for carcinoma of the rectum. The efficacy of 5-FU was tested by means of an infusion via the portal vein. This patient had not been asked informed consent; she was an unwitting participant in this potentially dangerous randomised controlled trial, as were other participants (Brahams, 1982).

Second, experimenting doctors can have conflicting interests. There are personal interests, of financial or scientific origin (status, promotion, funds), and there are patient-directed goals. These interests may clash, and personal reasons for conducting research may override the obtaining of informed consent, as I have found.

Third, the World Medical Association adopted the Declaration of Helsinki (1964, revised in 1975 in Tokyo) and approaches this problem also from the standpoint of patient protection. The main effect of the Helsinki Declaration is the setting up of an independent committee to consider, comment on and guide research proposals (para. 1.2) and the insistence on (preferably written) informed consent. The UNO covenant concerning Civil and Political Rights also prohibits medical experiments without consent (art. 7), but is not applicable to the USA, which has not yet ratified it.

Fourth, contrary to Hamilton's suggestions most patients do seem to want to know as much as they are able to understand about their treatment and the alternatives; surveys showed that "people have a universal desire for information, choice and respectful communication about decisions" (Caplan, 1982). They expected to have as much information about their treatment options as physicians could reasonably be expected to provide.

Fifth, it is my opinion that any investigation or treatment that is not an accepted norm in medical practice may fall outside the "consented area". Then, obtaining informed consent becomes necessary. Ethical committees should not be able to substitute their permission for that of the patient, as is the case now according to the Helsinki Declaration (Kemperman, 1982). If the patient is not capable of understanding the basic plan of management, he or she should be excluded from the trial. The patient should have the initial responsibility, even if he or she may show later on the wish to delegate it.

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PSYCHOSIS AND ANTIDIURETIC HORMONE

DEAR SIR,

There are certain features of Lever and Stansfield's report of a patient with Addison's disease, psychosis and the syndrome of inappropriate secretion of antidiuretic hormone (IADH) (*Journal*, October 1983, 406–10) that we feel merit further comment.

First, in attempting to explain the development of

SIADH in this patient, consideration should be given to the possibility that both the IADH and the psychosis were manifestations of a common disturbance of central nervous system (CNS) function (Raskind, Orenstein and Christopher, 1975). Second, antidiuretic hormone (ADH) *per se* may have been a factor in the development of psychiatric symptoms: Arginine vasopressin has been reported to influence various behavioural processes (Gold, Goodwin and Reus, 1978); significantly raised ADH levels have been reported in acutely psychotic subjects who had normal levels of serum sodium and osmolality (Raskind *et al*, 1978); and at the time of psychotic episodes the ADH level in Lever and Stansfield's patient was either inappropriately raised or greater than normal. Finally, although they were not being taken at the same time, phenothiazines could still have contributed to the elevated ADH levels in the first of this patient's psychotic episodes: these drugs may remain bound to CNS tissue many weeks after systematic withdrawal (Jose, Barton and Perez-Cruet, 1979); and IADH may occur as a late phenomenon following the cessation of phenothiazine therapy (Smith and Clark, 1980).

Whatever the precise mechanisms involved, Lever and Stansfield's report is apposite, for studies on the relationship between ADH and psychosis may further our understanding of psychotic disorders.

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... AND WATER INTOXICATION

DEAR SIR,

Recently Addison's disease has been reported in association with psychosis and inappropriate antidiuretic hormone secretion (*Journal*, October, 1983, *143*, 406-10). While this particular combination may be rare, disorders of fluid balance in psychiatric patients are more common than at present assumed (Blum and Friedland, 1983).

The syndrome of inappropriate antidiuretic hormone (IADH) occurs when ADH is provoked, not by the usual osmotic stimuli, but by other factors such as drugs, stress, and infection. This hormone excess leads to water retention and eventually water intoxication. Water intoxication may very rarely be produced by excessive intake but psychogenic polydipsia will not of itself lead to water retention as long as normal homeostatic mechanisms are present and able to cope with the fluid load.

We are particularly concerned with the misdiagnosis or underdiagnosis of water intoxication in chronic schizophrenia. Since the fluid retention is easily treatable and can be fatal if left untreated, it is important for psychiatrists to be aware of this possibility.

Water intoxication with or without significant IADH usually presents as a neurological disorder—headaches, lassitude, lethargy and vomiting progressing to seizures, coma and rigidity. Some of the early features can resemble the negative symptoms of schizophrenia but we are aware of two schizophrenics who were misdiagnosed in the advanced stages of the condition.

One patient was admitted to the medical ward with epileptic seizures and discharged undiagnosed, the other presented to a Casualty Department in coma and was transferred to a neurological unit as a head injury. In both cases the history did not help to establish the correct diagnosis. Both these patients presented during the heatwave this summer when any increased fluid intake was not recognised. One patient, who attended a psychiatric day hospital and lived in a group home, was not found to have polydipsia even retrospectively.

Serum ADH levels are not helpful in these acute situations since the samples require specialist handling and techniques, leading to a delay in the return of the result, and also, any particular individual's reference range will not be known.

We recommend the determination of a serum sodium level in any schizophrenic who is polydipsic, or develops impaired consciousness, unusual lethargy or seizures. The finding of a significantly lowered serum sodium value (less than 120 mmol/l) in the absence of