low dose". Dr Dabholkar raised the question of whether catatonia in itself is an indication for ECT. We hypothesise that ECT (or antidepressant medication) will be effective in treating hysterical catatonia and other conversion disorders only in cases where the conversion symptom serves as the 'masked' expression of an underlying depression (cf. Fisch, 1987).

In this regard, it should be noted that psychogenic pain disorders have been successfully treated with antidepressant medication (Walsh, 1983), and that electrically or chemically induced seizures have been successfully used in the treatment of "bizarre psychogenic movements" (Edwards, 1968), and in the treatment of psychogenic amnesia (Daniel & Crovitz, 1986).

In the case reported by Dr Dabholkar, it is plausible that the conversion symptoms may have served as an alternative to a major depressive episode; in other cases (Daniel & Crovitz, 1986) the development of conversion symptoms may even have served as an alternative to suicide. Since ECT has known anti-depressive efficacy (Gregory *et al*, 1985), its utilisation or an adequate trial of antidepressant medication may eliminate conversion disorders which have a depressive aetiology.

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Before Mrs Thatcher?

SIR: The Survey Psychiatric Assessment Schedule (SPAS, section 1), as described by Bond *et al* (1980), asks the subject who was the Prime Minister before the current Prime Minister, counting this as one item of twelve in the assessment of cognitive disorder. We wondered, given Mrs Thatcher's 9 years of office, whether this question is now appropriate.

To assess this, we randomly asked 50 members of hospital staff (age range 18–65) who the Prime Minister previous to Mrs Thatcher was. The results were that of the 50 people asked, only 24 answered correctly, i.e. 52% of a presumably cognitively unimpaired population were unable to answer this question.

We would therefore suggest that this item of information is no longer appropriate for use in psychometric assessment.

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Lipid-Lowering Drugs

SIR: There have been two large studies in which drugs have been used to alter the concentration of various lipoprotein components in blood. Cholestyramine, a non-absorbable sequestrate of bile acid, effectively lowers low-density lipoprotein (LDL); similarly gemfibrizol, a drug related to clofibrate, elevates high-density lipoprotein (HDL) and reduces LDL. It appears that there is a causal link between increased LDL and coronary heart disease, whereas raised HDL does not increase the incidence of coronary disease and may even have a protective effect.

In 1987 the Helsinki Heart Study (Frick *et al*, 1987), a prospective study of 4000 healthy men, showed that treatment with gemfibrizol produced a significant reduction of mortality from cardiac death compared with a placebo group. Similar results were observed with cholestyramine in the American Lipid Research Clinics Coronary Primary Prevention Trial (Lipid Research Clinical Program, 1984).

What is interesting is that in both studies the total death rates for the treated and untreated groups were not significantly different. This was accounted for by the fact that in the treatment groups in both studies there was an increased number of deaths caused by violence, accidents, suicide, or intracranial haemorrhage. In the Helsinki study 33% of the patients who died in the treatment group died from accidents, violence, or intracranial haemorrhage, as opposed to

12% of patients in the non-treatment group. In the Lipid Research Clinical Program study of the patients who died, 30% of those receiving treatment died violent deaths – accident, suicide, or murder – as opposed to 14% in the control group.

Lipids comprise about half the dry matter of the brain; the axon, the myelin sheath, and the synaptosomal membrane all having different proportions of lipid constituents; synoptic vesicles have a relatively high content of phospholipids. It is reasonable to assume, therefore, that anything which upsets the balance of cerebral lipid metabolism could have profound effects on the brain function. Several abnormalities of enzymes required for normal lipid metabolism are known to result in severe mental subnormality, e.g. deficiency of sphingomyelinase results in Niemann Pick disease. Disruption of the structure of the synaptic membrane or synaptic vesicles could disrupt normal function.

It is tempting to speculate how lipid-lowering drugs could affect the brain: cerebral lipids are synthesised in the brain from water-soluble precursors. Any alteration in peripheral lipid ratios are unlikely therefore to affect brain lipid metabolism. A direct effect of the drug itself in the brain could be postulated; however, cholestyramine is not absorbed from the gut. Gemfibrizol is absorbed, although its ability to cross the blood-brain barrier has not been established.

In both studies these results were interpreted as being a chance finding. We find these results most interesting and raise the question as to whether alteration of the ratio of HDL:LDL could be important psychiatrically.

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Tea and Antipsychotics

SIR: Silverstone *et al* (*Journal*, August 1988, **153**, 214–217) suggest that obesity in patients on long-term depot antipsychotics is most likely due to an increase in food intake brought about as a result of a drug-induced stimulant effect on appetite. There may be a possible alternative explanation for this weight gain, the clues to which lie in the patient's consumption of drinks. All antipsychotic medication has quite marked anticholinergic effects and, in particular, produces dry mouth. This leads to an increased consumption of drinks and, in particular, of the favourite British beverage of tea which is often taken with sugar. Simply drinking five more cups of tea per day would lead to an increased intake of 150 calories per day if milk and one sugar were taken. This net increase in calories would lead to an intake of 1050 calories per week, which could explain some of the weight gain. It only requires 7700 calories intake in excess of a balanced state in order to gain 1 kg in weight. On these calculations, 1 kg in weight would be gained every eight weeks. In addition, this effect would be accelerated because of the decreased activity which is one of the (often desired) effects of antipsychotic medication.

I have certainly observed this phenomenon of increased tea consumption in patients on lithium, and wonder whether this may be the underlying mechanism of weight gain with antipsychotics.

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A HUNDRED YEARS AGO

Inebriate Criminal Responsibility

A lecture on Inebriate Criminal Responsibility was delivered to the Society for the Study of Inebriety, at the rooms of the Medical Society of London, on Tuesday last, by the President, Dr Norman Kerr.

The lecturer reviewed the varying criminal procedure of different countries in criminal cases complicated with inebriety. Germany, Italy, and Switzerland recognised a culpable and inculpable intoxication; America, England, and France did not. Yet in America the confirmed was practically dealt with as a diseased drunkard, and capital punishment was averted by a verdict of "murder of the second