Our study at Addenbrooke's suggests that only 15,000 of the 75,000 patients really require this specialist assessment.

I am concerned lest psychiatrists should now leave hard-pressed physicians to undertake the initial psychiatric assessment of such patients without first ensuring that junior doctors and nurses receive instruction in this work and that psychiatric treatment and help from social workers are available once patients are discharged. What should be taught, and how consultation-liaison can be achieved, merit wider discussion.

May I restate two proposals made six months ago The first is that we invite the College of Physicians to join us in a meeting which would consider in detail teaching and liaison. The second is that we ask the Standing Medical Advisory Committees not only to review the arrangements for the treatment and after-care of self-poisoned patients, but also to initiate a detailed study of the prevention of poisoning. It will be recalled that the committee chaired by Professor Sir Denis Hill (3) met a decade ago and was unable to include the prevention of poisoning in its remit.

One of the aims of such a committee could be to formulate questions for which we need to find specific answers and then to advise the Department of Health about funding the appropriate research. In this way we might achieve a more favourable balance 'between guesswork and certainty'.

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References

1. GARDNER, R., HANKA, R., O'BRIEN, V. C., PAGE, A. J. F. & REES, R. (1977) Psychological and social evaluation in cases of deliberate self-poisoning admitted to a general hospital. *British Medical Journal, ii*, 1567–70.
2. MINISTRY OF HEALTH, HM (61), 94.
3. CENTRAL AND SCOTTISH HEALTH SERVICES COUNCILS (1968) *Hospital Treatment of Acute Poisoning.* London: HMSO.

MIANSERIN HYDROCHLORIDE

DEAR SIR,

Mianserin hydrochloride has recently been introduced as an antidepressant. Clinical studies have shown it to be an effective antidepressant (i.e. better than placebo, e.g. Murphy, 1975) and to be of about equal potency to standard treatments (e.g. amitriptyline—Coppen *et al*, 1976). The following case report provides some evidence on two further important features:

1. That mianserin may prevent relapses in recurrent depressive illness, and

2. Mianserin may be effective in some patients who fail to respond to other antidepressant therapy.

The patient was first seen three years ago (aged 24) when she gave a six-year history, which was confirmed by her general practitioner, of recurrent attacks of depressive illness which lasted a few weeks, resolved spontaneously but recurred. The illness appeared to be unaffected by diazepam or amitriptyline. Observation at psychiatric out-patients confirmed the patient's story. The patient suffered from a frequently recurring depressive psychosis, which was characterized by depression of mood, psychomotor retardation, pessimism, guilt and loss of sexual interest. Between attacks the patient was quite well. The episodes did not appear to be related to menstruation. The patient's treatment and response are shown in the accompanying table. For the first year

TABLE

Time	Treatment dose/day	Fraction of time depressed
0–1 year	Imipramine 100–150 mg	½
1–1½ year	Lithium carbonate 2,000 mg	0
1½–2 year	Lithium carbonate 1,000 mg	⅔
2–3 year	Mianserin 30–60 mg	0

the patient was treated with imipramine, receiving 150 mg per day for several months. She showed little or no response, being severely depressed for about half the time. For the second year, the imipramine was stopped and the patient received lithium carbonate. During the first six months of this year the patient received high doses (approximately 2,000 mg per day) to maintain therapeutic blood levels, during which time the patient suffered no attacks of depression. For the second six months of this year the dosage of lithium was reduced to approximately 1,000 mg per day because of lithium induced nausea. The plasma concentrations were then below therapeutic levels and the depressive episodes reappeared, the patient being severely depressed for about two-thirds of the time. For the third year lithium was stopped and the patient was

prescribed mianserin hydrochloride in doses varying from 30 mg to 60 mg per day, depending on the side effects. In the 12 months since commencing mianserin the patient has had no depressive episodes.

This patient's illness was obviously atypical in appearing at such an early age. However, it was typical in that it responded to treatment with adequate doses of lithium. Since, in the previous year, simply the reduction in dosage of lithium had led to the reappearance of the illness and, from a reliable history, the attacks had been occurring frequently over 8 years, it seems unlikely that the absence of depression when on mianserin was purely due to chance.

That mianserin may prevent recurrent depression is important, since our present therapeutic armamentarium for prophylaxis is very limited. Though we have at our disposal a large number of antidepressant drugs, most of them are pharmacologically very similar and in effect we have only a small number of distinct antidepressant treatments (ECT, tricyclic drugs, monoamine oxidase inhibitors with or without tryptophan). It is therefore of considerable importance that a new antidepressant may be effective when tricyclic drugs have failed.

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References

Murphy, J. E. (1975) *Journal of International Medical Research*, **3**, 251–60.

Coppen, A., Gupta, R., Montgomery, S., Ghose, K., Bailey, J., Burns, B. & De Ridder, J. J. (1976) *British Journal of Psychiatry*, **129**, 342–5.

DIAGNOSIS OF PSYCHIATRIC ILLNESS

Dear Sir,

While it may be true that the absence of laboratory investigations 'forces the psychiatrist to base his diagnosis firmly on the clinical interview' at De Crespigny Park (as indicated by Dr Leff, *Journal* (1977), **131**, 329–38), I do not think this is the case in everyday busy clinical practice, even in Aarhus, Agra, Cali, or Ibadan.

What most of us really do, is to try to get a history from an informant, or observe the subsequent course of the illness, or response to treatment.

An excited gentleman presenting himself at the emergency room at 2 in the morning, smelling of alcohol, and saying that he is the Emperor of China, might be one of many things. He could be manic, or schizophrenic, an acidhead, a speed freak, a drunk with a distorted sense of humour, a sociologist with a distorted sense of mission, or a descendant of the Manchus who lost his way to the men's room. My interview with such a patient would tell me little of much use at 2 in the morning, whereas five minutes with his family would give me the diagnosis, especially if they knew his previous response to lithium, sobriety, or phenothiazines.

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Dear Sir,

I am grateful to Dr Birkett for drawing attention to an apparent omission from my review. I certainly did not mean to exclude the psychiatric history in using the term 'clinical interview'. The reason my review deals exclusively with examination of the mental state is that published work on international comparisons of the influence of the psychiatric history on diagnostic practice is extremely sparse. However, there are some indications in the International Pilot Study of Schizophrenia that the psychiatric history plays a much greater part in shaping diagnosis in some countries than in others. The emphasis placed by Moscow psychiatrists on the course of illness and the patients' social adjustment allows us to infer that they would be extremely reluctant to make a differential diagnosis between schizophrenia and an affective psychosis without this information. Their colleagues in Aarhus, Agra, Cali or Ibadan, by contrast, would be much more likely to make such a diagnostic distinction on the basis of the mental state alone.

The other point raised by Dr Birkett is the lack of time available for examining the mental state in a busy clinic in whatever part of the world it happens to be. It is true, as mentioned in my review, that diagnostic decisions are made early on in the clinical interview, but there is considerable latitude, even within three minutes, for great differences in emphasis on phenomenology. Let us consider his point about the response to lithium indicating a diagnosis of mania. It is evident from both the IPSS and the US : UK project that up to a short time ago mania was virtually never demarcated from schizophrenia by American psychiatrists. Their rediscovery of the prophylactic effectiveness of lithium in mania has led to an increasing recognition by Americans of the existence of this condition. British psychiatrists, however, have been consistently making a distinction between mania and schizophrenia for many decades