between relapsing schizophrenics and controls, although we did not address this issue systematically.

The fact that Kraepelinians and relapsing schizophrenics have similar educational levels supports the hypothesis that VBR is related to disease severity.

Because the relapsing schizophrenics in these two studies were diagnostically very similar, sampled from consecutive admissions, matched demographically with their own controls, and differing only in educational level matching, we argued that the lack of such matching, considering educationally advantaged controls, could explain the remaining VBR difference when Kraepelinians are excluded.

We hypothesise that the most severe patients, 15% of our consecutive admission series, may strongly affect neuromorphological outcome and that if these patients are considered separately in statistical analyses, and educational level is matched, most schizophrenics do not seem to share ventricular enlargements, as in our second study.

Because most published studies on CT and MRI in schizophrenia do not provide information about educational level, outcome measures, or level of functioning in the social milieu, we suggest that researchers investigating neuromorphological correlates of schizophrenia should systematically address such issues.

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Abreaction before ECT?

SIR: There is renewed interest in the use of abreactive techniques. Patrick & Howells (1990) call for a careful and controlled reassessment of the use of barbiturate-assisted interviews for therapeutic and diagnostic purposes in psychiatric practice. In a recent report, Ellis (1990) described a case where he used diazepam instead of amylobarbitone, which was difficult to obtain due to export restrictions in the USA, to treat a case of hysterical paralysis. There have even been reports on the successful use of lorazepam intramuscularly in the treatment of psychogenic catatonia (Salam *et al*, 1987). The common practice of using diazepam for abreactive interviews in India has also been recently highlighted (Adityanjee *et al*, 1991). The amylobarbitone interview has been widely used in the assessment and treatment of mute and stuporous patients. These patients often do not eat or drink, are unable to accept or are resistive to oral medication, and present an immediate risk to their own health and safety. They are unable to give informed consent and this causes difficulties from a medico-legal point of view.

In practice, as soon as organic causes are excluded, ECT is usually the treatment of choice. As the patient is incapable of giving informed consent, a second opinion is obtained and, in the case of detained patients, this is done via procedures set out in the Mental Health Act, 1983, in England and Wales. When there is a delay and urgent treatment is necessary, ECT is administered under the provisions of Section 62. If the patient is informal, the clinician still obtains a second opinion as a matter of good practice.

In an audit of patients admitted in a stuporous state to a psychiatric department we found that there had hardly been any use of barbiturate- or diazepam-assisted interview. Our contention is that this evaluative and therapeutic procedure should receive more attention than it does at present. Abreactive techniques are likely to reduce the need to rush into giving ECT. However, the lack of clarity in the law relating to investigative procedures in emergency situations where patients are unable to give informed consent may lead to difficulties (Everall, 1987). Clarification of the law may well lead to increased use of this adjunctive measure in the evaluation of inaccessible patients. We are in the process of carrying out a wider survey to study the attitudes, training and possible legal difficulties experienced in the use of this procedure.

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Steroid-induced catatonia

SIR: The case report "A steroid stupor in a surgical ward" (Doherty *et al*, *Journal*, January 1991, **158**, 125–127) describes the development of secondary catatonia and stupor in a 17-year-old man. The patient had symptoms of bowel disease, became increasingly distressed at his failure to improve, and developed a catatonia syndrome upon the administration of steroids. He was treated with haloperidol and chlorpromazine for four weeks and then received ECT after which "he made an excellent response to a course of five treatments."

Anti-psychotic drugs were apparently given in the belief that the catatonia was a manifestation of a psychosis for which these drugs are deemed effective. But ECT has been known as an effective treatment for catatonia since the first experiments of Meduna with convulsive therapy in 1934, and those of Cerletti & Bini in their introduction of electroconvulsive therapy in 1938. There has not been any compelling evidence since then that any other treatment is as effective as ECT, although transient improvement has been reported after intravenous amobarbitone or thiopentone. Some authors have recently suggested that catatonia may be responsive to multiple doses of lorazepam, but such observations need verification and comparison with ECT before being accepted.

Present classification of catatonia as a subtype of schizophrenia, as in DSM–III, leads to the mind-set exhibited in this case: catatonia is a manifestation of schizophrenia and must be responsive to anti-psychotic drugs. But such a connection is fallacious. Catatonia is often described in patients with mania, depression, infections, endocrinopathy, and as in this case, secondary to drug toxicity. We have recently argued that catatonia should be considered a separate class in DSM–IV, distinct from schizophrenia (Fink & Taylor, 1991). Such a reclassification would have encouraged the physicians treating this patient to introduce ECT at the earliest opportunity, allowing the patient to recover sufficiently for any specific treatments for his bowel disease without the four week delay.

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Three thousand days of pregnancy

SIR: Recently, DePauw (*Journal*, December 1990, **157**, 924–928) reported an interesting case of monosymptomatic hypochondriacal psychosis (MHP) in which the somatic delusion was that of pain and pseudocyesis. This case, as reported, presented a major treatment problem as the patient's pain and delusional belief appeared to be refractory to a large number of psychotropic agents and ECT. In addition, although pimozide appeared to be effective, the patient was inconsistent in her response to this drug and finally required (40 mg), almost four times the dose of pimozide usually necessary to obtain symptomatic relief in MHP.

These observations prompt me to raise two questions about this case:

(a) As Dr DePauw points out, pimozide is an opiate antagonist. At the dose of pimozide utilised, could the patient's improvement be simply attributed to pimozide's effect on pain perception?

(b) Recent reports (Ross *et al*, 1987; Hollander *et al*, 1989; Fishbain & Goldberg, 1991) indicate that some forms of monosymptomatic hypochondriasis (MH) and MHP could selectively respond to serotonin reuptake blockers such as clomipramine and fluoxetine. Because of the success of the serotonin reuptake blockers where other agents have failed, one author (Ross *et al*, 1987) has suggested a controlled double-blind study of pimozide v. clomipramine for the treatment of MH–MHP. It is to be noted that no serotonin reuptake blockers were used in the treatment of this patient. One wonders if these would have had some measure of success?

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