

implicated a 5-hydroxytryptamine (5HT) as one of the likely neurotransmitters involved in the control of sexual responses, and this amine probably has an inhibitory role. Clomipramine and imipramine inhibit the re-uptake of 5HT, but also exhibit anticholinergic and alpha adrenoceptor antagonist activity. Cyproheptadine is a 5HT receptor antagonist. In two of the three cases reported cyproheptadine reversed the inhibiting effect of the anti-depressant on orgasm. These observations suggest that anti-depressant-induced anorgasmia results from the effect of these drugs on 5HT activity. Sovner (1984) also reported a case of tricyclic anti-depressant-induced anorgasmia which was reversed by cyproheptadine. More recently, Decastro (1985) successfully reversed MAOI-induced anorgasmia in a male with cyproheptadine.

In Case 3 the patient was prevented from increasing the dose of cyproheptadine by the occurrence of side-effects. Treatment with imipramine was changed to desipramine because Sovner (1983) reported the case of a woman who experienced anorgasmia with imipramine but not with desipramine, but in our case this change of treatment was ineffective in restoring orgasmic attainment.

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#### Depression and Urinary Free Cortisol

DEAR SIR,

The article by Dr R. J. Dolan and colleagues, "Life events, depression and hypothalamic-pituitary-adrenal axis function" (*Journal*, October 1985, 147, 429-433) reports some differences in urinary free-cortisol excretion between patients with and without severe life events or with and without marked difficulties.

It seems important to point out, however, that the actual 24 hour urinary free cortisol (UFC) excretion values ( $\mu\text{g}/24$  hours) were unusually high in all these patients, whether or not adverse life events and difficulties were present. All the mean values are

greater than  $145 \mu\text{g}/24$  hours. In most other studies the mean UFC excretion of normal subjects is about 40 to  $50 \mu\text{g}/24$  hours and in depressed patients the values rarely exceed  $100 \mu\text{g}/24$  hours (Carroll *et al*, 1976). The values given by Dr Dolan and associates are all well within the range expected for patients with Cushing's disease.

The authors stated that they used a radioimmunoassay procedure for their UFC analyses. The results call into question the validity and specificity of their assay or of the laboratory procedure they adopted. These considerations also would tend to raise questions about the validity of their plasma cortisol assays for assessing DST status of the subjects (Ritchie *et al*, 1985).

Radioimmunoassays for cortisol vary widely in their performance. For this reason, validation of the assay by establishing local norms always is to be encouraged.

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#### Complaints of Inability to Sneeze

DEAR SIR,

Shukla (*Journal*, November 1985, 147, 564-565) suggests asneezia as a previously unrecognised psychiatric symptom, yet fails to distinguish between the patient with a genuine absence or reduction in frequency of sneezing and the patient who complains of such but in whom there is no objective change. In the absence of this distinction, an alternative explanation is that he is reporting culturally determined hypochondriacal overvalued or delusional ideas. The following observations support this view.

Firstly, Dr Shukla highlights the importance of sneezing within Indian culture and it is well known that the content of such ideas is culturally dependent (Hamilton, 1974). Secondly, there were significant differences between the educational and socio-economic backgrounds of the asneezic and the control groups, and it has been widely suggested that patients of lower socio-economic groups and educational achievement are more likely to present with

somatic complaints (Connolly, 1979). Thirdly, hypochondriacal delusions occur in up to a fifth of schizophrenic disorders and are well known in affective disorders (McKenna, 1984) and these formed the majority of the asneezic group. Finally, the long duration and poor prognosis of such ideas in non-psychotic patients is well recognized (McKenna, 1984) and this is also in keeping with Dr Shukla's results. This would suggest that any further research be confined to the confirmation of asneezia as a genuine symptom. Only then can one consider the various biochemical hypotheses raised by Dr Shukla.

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#### Seasonal Variation in Suicides for Males and Females.

DEAR SIR,

There has been a recent series of papers in this *Journal* on the seasonal variation of suicide in males and females. In general, the papers (Meares *et al.*, 1981; Nayha, 1982; Parker & Walter, 1982) find a spring peak for males and spring and autumn peaks for females.

I should like to note that in the *Journal* (Lester, 1971), I reported on the seasonal variation in suicidal deaths in the USA and found a variation over the months of the year that was significant for males, for those using active methods of suicide and

for those aged 55 and over, but not for females, those using passive methods, and those aged 15–54. In a later article (Lester, 1985), I found the Spring peak for most methods of suicide, but the Autumn peak only for those using poisons.

Since the shape of the seasonal variation may vary with method for suicide, and age, as well as sex, these other variables must be controlled for before we can conclude that the sex difference is a reliable and valid phenomenon.

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#### Lithium in Resistant Depression

DEAR SIR,

In their carefully presented paper, Drs Schrader and Levien (*Journal*, November 1985, **147**, 573–575) have not in our view proved their point.

Could not the improvement have been the result of giving the lithium carbonate alone independently of whatever had previously been administered to the patient?

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#### CORRECTION

In the paper by Drs Birtchnell, Lacey and Harte 'Body Image Distortion in Bulimia Nervosa' (*Journal*, November 1985, **147**, 408–412) the paragraph on page 410 referring to Table IV should read as follows:

As is illustrated by Table IV, the distortion of body

perception in bulimics increased with deviation of weight index from 100%. The statistical comparisons that follow were made between the heavier intermediate group and the heaviest groups with the lighter intermediate group (normal weight index 95–105%) rather than the lightest group as published.