

5-point scale because the data being analysed were themselves summary statistics. However, due to the discrete nature of the data, and to the question of how different intervals on the fixed point scales related to each other, it would, alternatively, have been appropriate to adopt a non-parametric approach.

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Gilles de la Tourette's Syndrome in Down's Syndrome

SIR: We recently documented the occurrence and treatment of Gilles de la Tourette's syndrome (GTS) in an individual with Down's syndrome (*Journal*, May 1986, **148**, 601-604). Corbett (*Journal*, April 1987, **150**, 569) suggests that carbamazepine may have accounted for the late onset of GTS in this patient. However, as we indicated in the case report, the patient had been observed by nursing staff to have consistently displayed motor and phonic tics since the age of 11, when she was first institutionalised. We also mentioned that GTS had been diagnosed according to DSM-III criteria, which stipulate that age of onset must occur between 2 and 15 years. In contrast, carbamazepine had only first been used by this patient when she was aged 24, following the onset of a possible seizure disorder.

Corbett correctly points out that pharmacological compounds are increasingly being recognised as precipitants of tics. As indicated in the case report, although we attempted to correlate the presence and frequency of tics to the patient's previous use of medication we felt unable to do so accurately in view of the limited information available. However, tics appeared to have been continuously present since at least the age of 11, an interval that spanned the non-continuous use of several medications specified in the

case report, and antedated the introduction of carbamazepine by 13 years. Although carbamazepine possibly exacerbated her symptomatology, it was clearly not responsible for the onset of GTS manifestations in this patient.

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Onset of Schizophrenia in Men and Women

SIR: Stromgren has referred to studies indicating that onset of schizophrenia occurs later in women (*Journal*, January 1987, **150**, 1-7). Our experience in India is different.

We have been engaged in a multicentre 5-year follow-up study of schizophrenia, sponsored by the Indian Council of Medical Research, to find out factors associated with the course and outcome of schizophrenia. The centres selected for this study were Lucknow, Madras, and Vellore. All patients who attended psychiatry clinics in the participating centres between 15 October 1981 and 15 October 1982 and who satisfied a modified form of Feighner's criteria for the diagnosis of schizophrenia were included in the study (245 men and 141 women) (Verghese *et al*, 1985). The age of onset was calculated from the age of the patient at the time of inclusion and the time when the earliest abnormality was noticed (duration of illness). Both these pieces of information were given by the close relatives of the patients. Age of onset was found to be 25.87 ± 6.67 years for men and 25.89 ± 7.33 years for women, which suggests that age of onset of schizophrenia is not later in women in all parts of the world.

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Chronic Schizophrenia and Long-Term Hospitalisation

SIR: It is always useful for a psychiatrist interested in long-term patients to re-read *Institutionalism and Schizophrenia* (Wing & Brown, 1970), as Wing has reminded me (*Journal*, January 1987, 150, 129–130). I had hitherto thought that to do so with an eye to the questions it raises was fully in tune with the authors' intentions.

I do not dispute the book's conclusion that the negative handicaps of patients with schizophrenia are influenced by their current social milieu. My letter (*Journal*, September 1986, 149, 382) was prompted partly by concern that its evidence was given insufficient weight by Mathai & Gobinath (*Journal*, May 1986, 148, 509–516). I raised the different question of whether or not the institutional environment has a *cumulative* effect on negative handicaps such that they worsen progressively in the long-term, contrary to the case outside hospital (Bleuler, 1978).

I find it difficult to accept Wing's assertion that no one pattern of relationship between negative handicaps and length of stay in hospital is described. A summary (p. 87) states that "patients who were living in the most under-stimulating social environment were likely to show the greatest clinical poverty, and this complex was likely to be more severe the longer the patient has been in hospital"; a graph is said to show (Fig. 4.4 and p. 82) "the striking relationship between length of stay and three other factors, one 'primary' (social withdrawal), one 'secondary' (attitudes to discharge), and one 'social' (contact with the outside)"; and most revealingly (p. 183), "if social improvements had not been taking place at the hospitals the tendency would have been for the patients to have become more withdrawn and reticent, simply with the passing of the years. That such deterioration was mainly prevented, and that so large a proportion as one-fifth of the patients actually improved, is a considerable achievement".

I pointed out that the longitudinal course of individual patients shows the same tendency for deterioration to be concentrated in the early years, with later consistency, or even improvement, described outside hospital. The statistical association between length of stay and negative handicaps appears to result from selection combined with changes in the initial pattern of schizophrenic symptoms (Abrahamson, 1983).

The methodological issue is illustrated by Wing & Brown's treatment of the association between length of stay and unfavourable attitudes to discharge. The same graph is used to calculate the rate at which patients supposedly changed their attitudes year by year and leads on to the recently reiterated conclusion (Wing & Furlong, 1986) that negative attitudes accumulate gradually as part of a process of 'institutionalism'. This assumes that patients' initial attitudes have always been similar and ignores the possibility that those changes that do accumulate may follow discrete events such as loss of family or a home or transfer to a particular ward.

As the institutional era winds down it is important to refine the information with which we are left. That negative schizophrenic symptoms may be sensitive to the immediate effects of an impoverished environment yet resistant to its assumed long-term, cumulative moulding is relevant to future care and to any socio-medical model.

Equally, evidence that attitudes to discharge reflect realities rather than being explained by the gradual development of a secondary handicap has practical and ethical implications (Abrahamson & Brenner, 1982).

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DST in Apathetic Hyperthyroidism

Lahey (1931) drew attention to a form of hyperthyroidism which he called 'apathetic hyperthyroidism', occurring mainly in the elderly and lacking many of the cardinal features of thyroid overactivity. The predominant features were depression and apathy, and subsequent reports have confirmed his initial description (Thomas *et al*, 1970; Brenner, 1978). We report a patient fitting the description of apathetic hyperthyroidism in whom the dexamethasone suppression test (DST) was carried out.

Case report: A 69-year old widow presented with a three and a half year history of social withdrawal and isolation to the