hallucinations and persecutory delusions. Five days later she was overtalkative, very active, and irritable, and ten days later she had mild pressure of speech. She made a good recovery and was discharged on lithium.

It appears that one of Crammer's criteria for linking the menstrual cycle and the mental state has been fulfilled. While amenorrhoeic due to pregnancy, the patient remained well. Three days after birth she relapsed with a similar clinical picture to those episodes linked to the menstrual cycle.

I have now reported the case of a woman with a premenstrual psychotic illness who subsequently suffered from a puerperal relapse. This is complementary to those cases of puerperal psychosis and subsequent premenstrual relapse (Brockington *et al*, 1988) and adds substantially to the hypothesis that these phenomena have the same aetiology. One factor common to both the premenstrual and the postnatal period is the change in the sex hormones – and it has been argued that there is an interaction between changes in the levels of the sex hormones and dopamine receptor sensitivity (Wieck *et al*, 1992). Relapse of a puerperal psychosis has also been noted after the removal of a hydatidiform mole, when levels of gonadotrophins, progesterone and also oestrogen would be expected to fall (Hopker & Brockington, 1991). The circumstantial evidence that puerperal psychotic illness is secondary to falling levels of hormones is considerable. It does, however, remain true that there are a number of different hormones and neurotransmitters that may be responsible for this intriguing interaction.

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WIECK, A., KUMAR, R., HIRST, A. D., *et al* (1992) Increased sensitivity of dopamine receptors and the recurrence of affective psychosis after childbirth. *British Medical Journal*, **303**, 613–616.

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Gender differences in schizophrenia

SIR: Lewis (*Journal*, October 1992, **161**, 445–450) comments that gender differences in schizophrenia are established findings. Iacono & Beiser (1992) noted the conventional belief is that the incidence of schizophrenia is the same for both sexes. They commented that surveys over the past ten years have provided inconsistent results. They referred to studies in Asia, Europe, and North America, suggesting that an excess of schizophrenia does occur among males.

A prospective assessment of gender differences in psychiatric illness among a sample of 70 patients admitted to a psychiatric unit, in South Africa, showed the following results. The incidence of schizophrenia was more common among men than women ($P=0.003$). The majority of patients in the 10–30 year age group were men, while women patients predominated in the 30–50 year age group ($P=0.029$). This study showed that the men presented earlier with mental illness, this tending to be schizophrenia.

Dr Lewis comments on the biological basis for the male predominance. Though sociocultural factors relating to traditional societies may be unique in Africa, it would appear that results from South Africa are consistent with those from the rest of the world.

IACONO, W. G. & BEISER, M. (1992) Are males more likely than females to develop schizophrenia? *American Journal of Psychiatry*, **149**, 1070–1074.

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Carbamazepine and episodic dyscontrol

SIR: Sugarman (*Journal*, November 1992, **161**, 721) reports three individuals with outbursts of violence who responded well to carbamazepine. Interestingly, all had olfactory hallucinations and reported *déjà vu* experiences. These features point towards a diagnosis of temporal lobe epilepsy despite the absence of electroencephalogram (EEG) changes in two of the cases. Therefore, it is not surprising that the response to anticonvulsants was favourable.

I would agree the episodic dyscontrol may be "best understood as paroxysmal violence, due to epilepsy-like dysfunction of limbic structures in the temporal lobe", but this would appear to be a rather unfashionable view. I think it is worth noting that Maletsky's cases (1973) often had long histories of violent behaviour and, despite the 'out of character' quality of the episodes, I suspect many psychiatrists would have diagnosed them as suffering from an antisocial personality disorder.

The DSM–III–R criteria for intermittent explosive disorder have been designed specifically to exclude

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