evidence either for or against the suggestion that ECT may cause permanent cerebral damage.

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MAOI FOR OBSESSIVE COMPULSIVE DISORDER

DEAR SIR,

Obsessive compulsive disorder is a relatively uncommon illness, which in severe form is remarkably destructive to the patient and his or her family. The natural history of the disorder is poorly understood.

There are three papers in the literature (Swinson and Thomas, 1970; Annesley, 1969; Jenike, 1981) which present four cases that responded to monoamine oxidase inhibitors. Over the past few years we have had another four cases at our institution where monoamine oxidase inhibitors produced a rapid and sustained remission of symptoms. In all of these cases, numerous prior treatments had been unsuccessful in alleviating the symptoms.

In two of our cases, relapses occurred after the monoamine oxidase inhibitor was stopped and in both cases restarting the drug resulted in loss of symptomatology. All of our patients that responded to monoamine oxidase inhibitors remained free of symptoms at follow-up, which ranged from four months to four years. In the cases previously reported and in our four cases which responded to monoamine oxidase inhibitors, the patients all had phobic anxiety and/or severe anxiety associated with the obsessive compulsive disorder. At our institution, four other cases of severe obsessive compulsive disorder without associated anxiety or panic attacks, did not respond to monoamine oxidase inhibitors.

Our data indicate that at least a subgroup of patients with obsessive compulsive disorder respond to monoamine oxidase inhibitors, sometimes dramatically. Affective illness in the patient or his family was not a good predictor of responsiveness to monoamine oxidase inhibitors in our patients. The presence of severe anxiety or panic attacks, however, was uniformly associated with a good response in our patients. Sheehan, Ballinger and Jacobson (1980) have shown that phenelzine is effective in treating panic attacks and lowers the obsessive compulsive scores on the SCL-90 scale.

The authors feel that a trial of monoamine oxidase inhibitors is presently indicated in obsessive compulsive disorder, especially when phobic anxiety or panic attacks are part of the clinical presentation.

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HYPOALGESIA IN DEPRESSIVE ILLNESS

DEAR SIR,

Dr Hanks (*Journal*, October 1981, 364–5) considers my comments on the analgesic properties of tricyclic antidepressant drugs to be misleading (*Journal*, January 1981, 37–9). They certainly could be but a good deal hinges on the meaning to be attached to the word 'depression' in this context. To be sure, patients experiencing chronic pain can be miserable, unhappy and, on occasions, suicidal and despairing. But such emotions are not necessarily tantamount to a *syndrome* of depression as defined, for example, by Feighner *et al* (1972). In my experience tricyclic antidepressant drugs are rarely successful in relieving 'reactive' depression when experienced as unhappiness in the face of personal and environmental difficulties.

The possibility that some antidepressants have specific analgesic properties apart from their antidepressant ones is suggested by the three following observations:

(1) Intractable pain is sometimes relieved by quite small doses of anti-depressants, doses far lower than those generally required for the successful treatment of endogenous depression.

(2) Relief of chronic pain is sometimes achieved after quite short periods of treatment—48 hours in some cases—which are far shorter than the time required for remission of a depressive syndrome (Gade *et al*, 1980; Turkington, 1980).

(3) It has been observed that drugs such as clomipramine and zimelidine with more specific blockaging effects on serotonin receptors have more effective analgesic properties than mianserin and maprotiline which are potent inhibitors of noradrenaline uptake. Furthermore, a serotonin precursor such as l-tryptophan (King, 1980) sometimes promotes analgesia in chronic pain patients and appears to potentiate endogenous opioids (Lee *et al*, 1979).

The precise mode of action of some antidepressants with analgesic properties is unclear but I agree with Dr Hanks that extrapolation from experiments on animals subjected to acute pain is unlikely to be relevant to human patients suffering from severe, intractable, chronic pain. Possibly antidepressants have peripheral as well as central activities as suggested by Massey and Riley (1980), who considered that they could affect neuronal and axonal transmission: hence their special benefit to patients with diabetic and other neuropathies.

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POLYGLOTTISM AND DEPRESSION

DEAR SIR,

Dr Hughes in his review of bilingualism (*Journal*, July 1981, **138**, 25–8) refers to the relation between primary mood disorders and language preference. I report that polyglottism occurs in affective disorders significantly more often in patients with bipolar than unipolar depression (Kun *et al*, 1978). Polyglottism is defined here as the knowledge of *two* or more foreign languages acquired by active learning rather than by birth in a foreign-speaking family or settling in a foreign area. We studied 245 consecutive acute female admissions who met the Feighner (1972) criteria for bipolar and unipolar depression. We established the presence or absence of polyglottism after recovery.

Of 126 bipolar depressives 36 (29 per cent), and of 119 unipolar depressives 7 (6 per cent) were polyglot; a significant difference ($\chi^2 = 21.77$; df = 1; $P < 0.001$). There is no significant difference related to the educational or social levels of the patients. The knowledge of two foreign languages in the general Hungarian population is 4.2 per cent (Terestyeni, 1980), not very different from the 6 per cent found in our unipolar patients.

I wonder if good ability to learn foreign languages is related to extrovert (Murray and Blackburn, 1974), cyclothymic (Akiskal *et al*, 1977) or 'attention-seeking' (Zuckerman and Neeb, 1979) aspects of premorbid personality found more in bipolar than unipolar patients? Further studies are needed.

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