1978, **133,** 382) felt consistent with a diagnosis of temporal lobe epilepsy, and which falls under Article 11 of the *Fundamentals of Criminal Legislation of the USSR* classified as a temporary mental disorder, the diagnosis made along the lines described by Rozhnov (1970). However, Hunter Gillies (1965) describes how in his experience 'psychiatric explanations of this type were poorly received by the courts'. Caplan (Hobson, 1962) suggested that such an explanation would be acceptable to lawyers, but the problem is knowing 'where the disease begins and where it has not yet begun'. Similarly, there is no way at the present time of providing acceptable objective evidence, required by this country's lawyers, that such a condition has ever existed in an individual.

Dr Pierce James' letter is important in raising the issue of pleading manslaughter when it can be shown that the accused did not possess the ability to form an intent to murder, as there appears to be a grey area between simple drunkenness, which is no defence to murder, and a McNaughton verdict. One must symphathize with the position of a defence psychiatrist on such a case in his difficulty to demonstrate that a confusional state or non-insane automatism had existed in the patient, or to make the uncertain attempt to base a plea of manslaughter on points of law.

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[This correspondence is now closed—*Editor*]

SELF-REPORT OF SLEEP DEPRIVATION THERAPY

DEAR SIR,

This 46-year-old lady had suffered phases of alteration of mood for 20 years, but for the last five years had been consistently depressed between September and March, with marked lethargy and despair in the mornings, frequent wakening during the night, and a loss of appetite. Each depressive phase had been preceded by a week of elation, accompanied by unusual physical exertion and loud singing around the house. She had been admitted to hospital and treated with imipramine during a previous phase, without marked alteration in the time course of the mood changes. Her premorbid personality was cyclothymic and obsessional, and she had had a sister with similar phasic changes treated as an in-patient.

Even in a depressed phase, she continued to work two nights a week on Friday and Saturday, and her husband remarked that she was back to normal on returning home at 8 a.m., though this was normally her worst time of day. However, after making up her sleep on Sunday night, she once more awoke depressed on Monday morning.

This short-lived lifting of depressed mood is the same as that described by Bhanji and Roy (*Journal*, 1975, **127,** 222–6), whose work was quite unknown to both the patient and her husband.

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NO LUNG CANCER IN SCHIZOPHRENICS?

DEAR SIR,

I was much intrigued by the observation of Dr David Rice (*Journal*, January 1979, **134,** 128) that he cannot recall a single case of a chronic schizophrenic patient dying of bronchial carcinoma. However, the same extraordinary low incidence of bronchial carcinoma is to be found in the long stay subnormality hospitals. I have for some years been concerned about the number of patients not receiving an adequacy of pocket money where the long stay hospitals have been so poor that the management have not felt themselves able to give patients the amount of money laid down as standard by the Department. (This problem has now, of course, been largely eliminated since the introduction of NCIP). In trying to convey my anxieties to my colleagues in an arresting fashion, I have used the flippant phrase, 'In 20 years of hospital psychiatry, I have never had a patient rich enough to get bronchial carcinoma'. To smoke 40 factory-made cigarettes a day would cost a patient £7 per week.

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