treatment, compared with normal subjects, or during treatment with antidepressants.

In the light of these findings perhaps the decision to leave out a detailed discussion of the melatonin literature from the review of circadian rhythms is more comprehensible.

CHRIS THOMPSON

Senior Lecturer in Psychiatry

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Dr Roy-Byrne and colleagues reply

We want to thank Dr Thompson for pointing out our error. He is correct, of course, in affirming that tricyclic antidepressants slow the frequency of free-running circadian rhythms. Therefore, the effect of oestradiol on circadian rhythms is *opposite* to that of tricyclics. We hope that this theoretical error has not detracted from our attempt to provide a practical overview of the clinical management of the rapid cycling patient.

PETER P. ROY-BYRNE
RUSSELL T. JOFFE
THOMAS W. UHDE
ROBERT M. POST

Alcohol, Drug Abuse and Mental Health Administration,
National Institute of Mental Health,
Intramural Research Program,
Bethesda, Maryland

TREATMENT OF RAPID CYCLING AFFECTIVE ILLNESS

DEAR SIR,

In their paper Roy-Byrne *et al* (*Journal*, November 1984, **145**, 543–550) indicated a need for further systematic study to assess the definitive role of neuroleptics in treating this condition. The depot preparation of haloperidol decanoate became available in the U.K. on a research basis in the autumn of 1981 and my clinical experience to date includes the treatment of fifteen patients with a diagnosis of manic depressive psychosis, four of whom form a distinct subgroup of rapid cycling affective illness. They have a combined history of eleven hospital admissions for hypomania in the previous two years while on lithium (serum levels 0.50 to 1.0 mmol/l) and oral neuroleptics. These frequent admissions resulted in a total of twenty three months in-patient treatment (almost six months per patient) before starting haloperidol decanoate in a dose range between 100 and 400 mg monthly. There have been no re-admissions for hypomanic relapses, all four patients having received this treatment for over 36 months, and two short lasting depressive episodes in one patient were successfully treated as an outpatient by adding a tricyclic antidepressant. The result of this open study certainly supports the authors' proposition that prolonged neuroleptic treatment, possibly in combination with lithium, may reduce the severity and frequency of manic episodes.

M. R. LOWE

Basildon Hospital,
Basildon, Essex

IS THERE REALLY A SCHIZOPHRENIA? THE LONG-TERM COURSE OF PSYCHOTIC PHENOMENA

DEAR SIR,

As my article (*Journal*, December 1984, **145**, 636–640) could not be published in full, some additional points, included in the original manuscript, may be helpful for understanding my thesis. According to systems theory, identical states may be reached by way of very different combinations of influencing factors (the principle of equifinality). On the other hand, identical states can evolve, under varying circumstances, in very different directions. Both phenomena are currently observed in the long-term course of psychotic states diagnosed as schizophrenia. With other arguments presented in the paper, this speaks against the classical concept of a clearly delimitable disease entity with constant causes, psychopathological picture, and course. A more flexible view, based on the vulnerability- and