

families. There was also no clear relationship between the area of injury and the frequency or severity of psychological after-effects.

Thus, although I would accept that premorbid vulnerability may indeed be an important predictor of psychological outcome following a frightening event, the overwhelming majority of victims in my study who developed post-traumatic stress did not have a past psychiatric history.

A. C. WHITE

Queen Elizabeth Medical Centre
Edgbaston
Birmingham B15 2TH

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Listeria and psychiatric syndromes

SIR: In view of the recent publicity given to the almost forgotten listeria monocytogenes, it might interest psychiatrists to know that outwith the British Isles this bacterium has been incriminated as the causative agent in a wide variety of psychiatric syndromes. Although abortion most readily springs to mind in association with listeria, studies have shown that the syndrome most commonly occurring in man is the meningeal encephalitic form (Seeliger, 1958; Colmant, 1961). As would be expected, psychiatric syndromes are described in cases where the condition has become subacute and chronic.

In the German literature, Lang (1955a) described five children who had raised listeria titres in the course of recurrent bouts of disturbed behaviour with screaming and temper tantrums, all of which disappeared after adequate treatment with antibiotics. Lang (1955b) also claimed to have found a high incidence of raised listeria titres among a group of 300 children from the Bonn area suffering from different types of brain damage. Seeliger (1958) described a patient who in the course of a recognised listeriosis infection developed a manic illness which lapsed into a chronic depressive state and eventually led to suicide. In the Russian literature, Timofeyeva *et al* (1953) described three cases presenting with predominantly schizophrenic symptoms. Recurrent bouts of temperature together with a raised listeria titre strongly suggested that listeria was responsible for the psychiatric symptoms.

So far listeria seems to have made little "headway" in Britain, and hopefully this will continue to be the case. However, Colmant (1961) warned that although listeriosis is an illness resembling tuberculosis and

syphilis in its complexity, its diagnosis depends on the familiarity of the doctor with the illness. Listeria fell from grace and general interest after it was found not to be the cause of infectious mononucleosis in man, following its original discovery in 1924 in Cambridge by Murray *et al* as a monocytosis producing bacteria in laboratory rabbits. However, given its known predilection for soft cheeses, perhaps it now merits shortlisting as a possible causative agent in psychotic gourmets.

JANICE M. DUNCAN

The State Hospital
Carstairs Junction
Lanark ML11 8RP

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The Melbourne Maudsleys

SIR: Readers of Henry Maudsley's autobiography in the *Journal* (December 1988, **153**, 736–740) may be interested in some further family history. Maudsley paid a visit to Australia in 1903, apparently to see "the best of cricket in its best home". I wonder, however, whether the visit offered an opportunity to meet his nephew, also Henry Maudsley (1859–1944) and his great-nephew, Henry Fitzgerald Maudsley (1891–1962). Both Australian members of the Maudsley family were prominent physicians, with the younger Henry being a key figure in the development of Australian psychiatry.

Henry Maudsley (1859–1944), like his uncle, was born in Yorkshire, near Settle. He obtained his MB BS at the University of London in 1881. Again like his uncle, some 30 years previously, he was a medical officer at University College Hospital. He migrated to Australia and settled in Melbourne in 1888. In 1903 he joined the staff of the Melbourne Hospital and was Lecturer in Medicine in the University of Melbourne. He became a leading consultant physician and, unlike his uncle, was knighted (Obituary, 1944).

A short biography of his son, Henry ('Hal') Fitzgerald Maudsley, has recently been published