

admittedly flawed, sociological and statistical study of suicide rates as an index of pathological forms of the division of labour. This stems from a positivist desire to study rates, rules and types of social phenomena rather than enquiring about (unknowable) individual intentionality. This is one solution to a dilemma not unknown to psychiatrists attempting to make sense of phenomenological data through the use of epidemiology and operational criteria.

KEITH LLOYD

*Bethlem Royal Hospital
Beckenham
Kent BR3 3BX*

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There are none so double-blind . . .

SIR: Oxtoby *et al* (*Journal*, November 1989, **155**, 700–701) raise important points in their significant and elegant article.

Surely journal editors should follow the policy they imply? No article should be accepted for publication, which includes the claim to have been a 'double-blind' drug trial, unless it contains clear data establishing the validity of that claim. It is decidedly odd that hitherto, editors have required only the *simulation* of double-blinding, rather than the reality of how the technique is effectively used.

The experience reported by Oxtoby *et al*, of failing to gain publication of their valid and important critiques, raises another most important caution concerning the scientific literature. In my experience there is in practice a significant rate of rejection of articles and letters critical of substantial methodological flaws in studies; a rejection rate that is unrelated to the truth or relevance of the criticisms, or to the quality of the written submission. There may be several reasons for this. Editors and reviewers (consciously and unconsciously) might not be well disposed to submissions that demonstrate serious flaws in articles they have accepted for publication; especially if the authors of the faulty articles are significant establishment figures.

Another problem arises from the attempts to seek 'peer' review. Items obviously need to be reviewed by experts. However, especially within some fields, a regular ring of reviewers develops, whose personal and emotional investment in particular views lead them to urge rejection of contrary ones. One should be very cautious of using reviewers too prominent or dominant within their field.

This was well demonstrated recently, when this *Journal* (Simpson, *Journal*, October 1989, **155**, 565) published a letter in which I criticised some of the many flaws in the burgeoning fad literature on multiple personality disorder (MPD). I have since received numerous sustaining and supportive letters from American readers, delighted to have seen criticism of this sacred cow of the psychosocial literature actually appear in print. In North America, it is almost impossible for such critical views on MPD to appear in print because all such submissions are reflexly sent for review to a small circle of devotees of MPD, who reject them.

As scientists, authors, reviewers and editors, we should value sincere and informed critics far more highly, for they are a valuable but endangered species. Our disciplines need to treasure iconoclasts and there are more than enough of these about.

MICHAEL A. SIMPSON

*PO Box 51,
Pretoria 0001
South Africa*

Malaria presenting as atypical depression

SIR: We report here a case of a patient with cerebral malaria who presented in the UK with a hysterical stupor occurring in the context of an atypical depression.

Case Report: A 30-year-old woman was admitted under Section 2 of the Mental Health Act (1983) following a domiciliary visit. She had been stuporose for 48 hours and had stopped eating and drinking. On returning from a day trip to the seaside she had been quite unable to get out of the car because of her semistuporose condition and resisted any attempts to move her, even by force. Prior to this episode she had complained of bouts of extreme tiredness, depression and irritability for about four months. She also had sleep reversal, with daytime sleepiness and nocturnal insomnia. There was no weight loss, but appetite was impaired. Her family history was negative for all psychiatric disorders, but seven years previously the patient had taken an overdose following the break-up of a relationship. Early life and schooling were unremarkable and she had been successful in her career as an information officer. At the time of the onset of depression, she had been in dispute with a girlfriend with whom she had shared a flat. In addition, six weeks prior to admission she had got married and reported some difficulties in forming a relationship with her stepson. It was thought that her recent life events were sufficient cause for her depression. Her general practitioner (GP) had started treatment with imipramine with a good initial response. However, she stopped the drug because of side effects and this appeared to coincide with the onset of deterioration in her clinical state and the onset of stupor.

During the admission to hospital, she took to her bed for two days every 3–4 days, complaining of severe exhaustion

and sleepiness. She would then have a few days when she appeared to be quite well and took part in ward activities. Even though all routine haematological and clinical tests were normal, an organic cause for her depression was suspected. An electroencephalograph (EEG) recording showed some temporal theta-wave activity, associated with drowsiness and slow-wave activity of 2–3 cycles per second on overbreathing. This was unusual for her age.

The diagnosis of malaria was only reached during the fourth psychotherapy session, when she began to describe her brother's marital problems. Her brother had married a woman in Bangkok and when this relationship had foundered, her brother became depressed. Together with her parents, she visited him in Bangkok to console him. While describing this visit, she added that they had visited a malaria-infested island and, as an aside, commented that she had not completed her course of antimalarials on her return to the UK. On this information a blood film for parasites was done and the film showed trophozoites in the smear. She was then treated with chloroquine for five days and primaquine for two weeks, and felt considerably improved but her depression remained and this only resolved following a course of fluoxetine (20 mg nocte).

According to Daroff *et al* (1967), cerebral malaria can present with five different neuro-psychiatric syndromes. In order of frequency, these are: disturbances of consciousness; stupor and coma (most common); acute delirium; acute psychosis or personality change; movement disorder with tremors, and a stroke-like syndrome with focal neurological defects. Redlich & Freedman (1966) highlight cases which are subacute or chronic, where apathy and depression may predominate. Gopinathan *et al* (1982) presented six atypical cases of cerebral malaria where there was neither fever nor parasitaemia. Our patient had episodes of semistupor, yet remained afebrile despite careful monitoring over a four-week period. An organic aetiology for our patient was suggested by the EEG changes, which were similar to the bilateral slow-wave changes demonstrated by Le Mercier *et al* (1969) in their study of 76 cases of cerebral malaria. In our patient the diagnosis proved elusive despite

five independent medical assessments, possibly because of a very low index of suspicion and consequent failure to elicit a comprehensive travel history from the patient. Carothers (1953), working in Kenya, estimated that 3% of all first admission cases to mental hospitals were suffering from cerebral malaria. With increasing foreign travel to areas endemic for malaria, psychiatrists in the UK as well as physicians will need to be aware of the possibility of malaria in cases of depression presenting atypically.

M. V. ARUN PRAKASH

Hayes Grove Priory Hospital
Prestons Road
Hayes, Kent BR2 7AS

GEORGE STEIN

Farnborough Hospital
Kent

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Corrigenda

Journal, November 1989, **155**, 725. A. S. Henderson is the author of *An Introduction to Social Psychiatry*, not the editor.

Journal, February 1990, **156**, 285. S. H. Verma should read S. M. Verma.

A HUNDRED YEARS AGO

Clinical observations on the action of sulphonal in insanity

Dr Mabon records a series of observations on patients suffering from simple melancholia, melancholia agitata, acute and chronic mania and dementia. Sulphonal was administered 119 times on 114 nights, in doses of 15, 30, 45 and 60 grains. Generally 30 grains were required to bring about a quiet and refreshing sleep. It was given at first suspended in mucilage, but later in hot milk and hot

gruel, the advantage of the latter menstruum being increased promptness of action. Dr Mabon thinks that the advantages of sulphonal over other hypnotics are the absence of disturbances of digestion, secretion, circulation, and respiration; its easiness of administration, its tastelessness, its odourlessness, and the resulting sleep closely approximating that of nature.

Reference

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Surrey