The recent open reports of five cases of body dysmorphic disorder (DSM–III–R), where ideas about body deformities bordered upon the delusional in the absence of prominent depression, and where the patients responded to treatment with 5-HT-reuptake inhibitors in preference to a variety of other antidepressants and neuroleptics, are consistent with the proposal of a common serotonergic pathology underlying some monosymptomatic delusional disorders and OCD (Hollander *et al*, 1989). Depressive symptoms commonly occur as part of OCD, and the concept of OCD as a syndrome composed of a spectrum of symptoms including delusions has gained some recognition (Solyom *et al*, 1985).

However, open reports of drug responses are notoriously unreliable and it is a pity that Dr Chiu's cases also fall into this category.

Controlled investigation of non-depressed individuals with monodelusional states, examining the efficacy of 5-HT-reuptake inhibitors and neuroleptics, either alone or combined, are indicated to explore OCD and delusions more thoroughly.

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Unmet needs for medical care

Sir: Brugha *et al* propose a potentially useful concept in their paper on unmet needs for medical care in the long-term mentally ill (*Journal*, December 1989, **155**, 777–781). However, because of suspect methodology and inadequate evidence (at least as reported in the paper) it is impossible to accept their conclusions.

Firstly, in a paper discussing physical health and illness, it is difficult to understand the rationale behind not performing a physical examination on each patient. The authors acknowledge this, but do not attempt to explain it. Nevertheless, they claim the presence of dental or gum disease in 28% of those "who were examined".

Secondly, the authors make two quite unsubstantiated claims regarding the particular value of thyroid and liver-function tests and the finding that need for medical care was equally likely in users of non-hospital day services. They are obvious important implications for both these claims, but it is impossible to judge their merits without being able to examine the evidence underlying them.

The final, and perhaps most glaring omission, is the absence of any reference to the primary health care services. It seems highly likely that the level of unmet need for medical care in a defined population is highly dependent on the local primary care services. The knowledge, concern and skills of the primary care team, together with the liaison between the primary and mental health care teams, particularly regarding responsibility for the physical care of these patients, will surely influence the levels of unmet need in the population.

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Glucose metabolic rate in schizophrenia

Sir: A decrease in the glucose metabolic rate in the right frontal lobe in schizophrenics compared with controls (assessed by positron emission tomography during a continuous performance test) (*Journal*, February 1990, **156**, 216–227), and a significant reduction of mixed- and left-handedness in male epileptics with schizophrenia (*Journal*, February 1990, **156**, 228–230) suggest a protective role for lateralised brain function. This is supported by norepinephrine-induced exacerbation of schizophrenia (van Kammen *et al*, 1990), manifested by auditory hallucinosis during oculogyric crises (*Journal*, July 1989, **155**, 110–113 and October 1989, **155**, 569–570), which may be elicited by noradrenergic-mediated inhibition of dopamine lateralised to the right hemisphere (Rascol *et al*, 1989 and *Journal*, February 1990, **156**, 285). In contrast, compulsions were characterised by prolonged spin-lattice relaxation time on magnetic resonance imaging in the right frontal cortex (Garber *et al*, 1989), and auditory-visual hallucinations preceding oculogyric crises were perhaps induced by fatigue in a non-schizophrenic epileptic woman (Leigh *et al*, 1987).

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Inter-relationships among mental and motor symptoms, including gaze and thought disorders, sequentially analysed on a time-base, handedness, gender, lateralised brain functions and detailed gyrus-by-gyrus analysis of the frontal lobe (*Journal*, February 1990, **156**, 216–227) may provide an understanding of how specific patterns of monaminergic overactivity lead to the cognitive disturbances that are clinically significant and a hallmark of schizophrenia (Braff & Geyer, 1990).

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Failure of progesterone treatment in puerperal mania

SIR: Progesterone is widely used in the treatment and prophylaxis of post-natal depression (Dalton, 1985). Sedative effects have been reported when this hormone is given intravenously (Merryman *et al*, 1954). If the onset of psychosis in the early puerperium is related to the precipitous fall in circulating progesterone after childbirth, progesterone therapy might be of benefit in early-onset puerperal mania.

We tried this therapy with three patients, all of whom expressed a preference to try hormonal therapy rather than neuroleptic drugs. The first patient, with a seven-day history of mania starting six days post-partum, reported a subjective calming effect with progesterone (50 mg intramuscular) before and after neuroleptic therapy was commenced. The second patient had suddenly become manic on day four post-partum; administration of progesterone (100 mg) on day six, and repeated after 12 hours, was associated with a surprising return to normality over 24 hours. She had, however, received chlorpromazine (50 mg intramuscular) and haloperidol (40 mg intramuscular) over the 24 hours before being given progesterone. These experiences suggested that intramuscular progesterone was well tolerated and might have an antimanic effect, and encouraged us to use it as the sole therapy in a typical case of puerperal mania.

The third patient had suddenly developed puerperal mania on day seven post-partum and had only been given oral chlorpromazine (100 mg) before progesterone was started. Progesterone (100 mg intramuscular, 12 hourly) was commenced as the sole therapy 12 hours after the onset of the disorder and continued for one week. A random blood level late in this week was 476 nmol/l (about average for levels in late pregnancy). There was *no effect at all* on her mental state with this regime. After switching to standard neuroleptic therapy, a significant improvement occurred within a few days. While we would not wish to discount the possibility of a beneficial effect of progesterone on the basis of one case, we think it important to give publicity to this definite therapeutic failure.

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Post-traumatic stress disorder

SIR: Medley *et al* (*Journal*, January 1990, **156**, 134) raise two important issues in relation to post-traumatic stress disorder (PTSD).

The debate over the relative importance of the trauma itself and pre-existing personality factors and psychological morbidity is likely to be around for some time to come. Of more immediate clinical importance is the diagnosis of PTSD in survivors of catastrophic accidents who have sustained significant head injury. DSM–III and DSM–III–R both indicate that the first criterion for the diagnosis of PTSD is that the individual has 'experienced' an extreme or catastrophically stressful life event. Survivors, such as those who survived the recent crash on the M1, who were immediately rendered unconscious and remained so while they were being rescued, would not have 'experienced' the event. It should not therefore be expected that they would

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