only two. They found a 10–20 kg weight gain in 21% and 2% of their patients respectively, and though difficult to compare directly, the percentages of excessive weight gain and complaints of the same are almost identical in both studies.

Gastro-intestinal disturbances including nausea and vomiting, loose motions and a salty taste in the mouth was reported by 3%; 6% of their patients had diarrhoea.

Seven per cent had raised serum creatinine levels (> 125 μmol/l) but 28% had at least one raised level at some time previously; 3% had persistently raised levels (3 or more consecutive levels) with mean values ranging from 137 to 184. Only one of these had a creatinine clearance and this was normal. Of their patients, 0.7% had a raised serum creatinine (> 130 μmol/l) but none of these showed any significant reduction of creatinine clearance on lithium.

There were no symptomatic cases of lithium toxicity compared to two cases of toxicity in their study. We had three suicides of clinic patients, not involving lithium and they had the same number.

In conclusion, our audit has shown that monitoring frequency for thyroid and renal function ought to be reduced, creatinine clearances obtained for persistently raised levels, the rationale for daily divided doses of lithium reviewed and patients weighed at each visit. Otherwise, the lithium clinic provides a cost effective service, with potential implications for general practitioner budget holders and other purchasers of psychiatric services.

PATRICK O'BRIEN

Fulbourn Hospital
Cambridge CB1 5EF

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Clinical audit

DEAR SIRS

I read with interest the letter from A. K. Shah (*Psychiatric Bulletin*, December 1990, **14**, 748). The form of clinical audit which he comments upon had been practised for some time in our Department of Psychiatry. For the past 18 months we have held fortnightly audit meetings, and in alternate meetings a consultant has reviewed the case notes of a patient randomly selected from another consultant's team. The review of the notes follows a standardised format and covers three areas. The first area is the structure of the records and looks at whether the appropriate paperwork is present and filed correctly. The second area looks at the content of the notes and sees whether an adequate history is taken, mental state recorded, physical examination made, investigations performed and progress notes recorded regularly. Also a discharge plan is looked at and the timing and adequacy of the discharge summary is noted. The third area is management appraisal where the objective is to see how well the case in managed.

A recent South-West region audit meeting showed that this form of case note review has been widely adopted by psychiatric departments in the South-West. Despite some problems at first, generally the experience has been a positive one. In Exeter, the main disadvantage at first was that the juniors felt somewhat paranoid as they were initially excluded from the audit meetings and it was mainly their work which was being scrutinised. This was readily addressed by the inclusion of all grades of medical staff in the audit meetings. The gains from this process have been marked. Firstly, we are now much more aware of our colleagues' working practices. Secondly, we are now more critically aware of our own standards of work and ways of improving these. Finally, it seems that this has had a generalised effect on raising morale.

SARAH OKE

Wonford House Hospital
Wonford, Exeter EX2 5AF

DEAR SIRS

I read with interest Dr Shah's letter (*Psychiatric Bulletin*, December 1990, **14**, 748) describing an intensive and confrontational form of clinical audit in the field of medicine for the elderly. Such methods are not new, and are certainly finding their way into psychiatric practice and education in Liverpool.

Five years ago, I was a senior house officer in geriatrics in North Wales, and attended fortnightly meetings in which consultants from another team would present a detailed audit of one or two sets of recent case notes in a similar way to that described by Dr Shah. This exercise was, indeed, frightening, not least to the junior medical staff, but had clear educational value, improving my own standards of notekeeping enormously.

These methods are now to be used on a regular basis in the case conference meetings normally presented by postgraduate psychiatry trainees in

https://doi.org/10.1192/pb.15.3.166-a Published online by Cambridge University Press

Liverpool. The audience will include medical staff from other teams, undergraduates, social workers, psychologists and others from allied professions, and it is expected that these meetings will raise standards of education and management to the benefit of all users of the service.

G. T. RIDLEY

Halton General Hospital
Runcorn, Cheshire

A register of Munchausen cases?

DEAR SIRS

I recently encountered an interesting variant of Munchausen's Syndrome. A young man was admitted to an adult medical ward with acute bronchorestriction. He said that he was 14 and had nowhere to live. Both his parents were dead and he had been brought up by his step-father who had sexually abused him. For the previous week he had been hitch-hiking around the country. When the hospital social worker and I interviewed him the next day, he tended to ignore me, but smiled warmly at her and held her hand. His manner was remarkably immature for his stated age but his mental state examination was otherwise normal. His bronchorestriction had completely resolved.

As he had threatened to abscond, the social worker considered using a Place of Safety Order if he attempted to leave the ward. Eventually we were able to establish that he was an 18-year-old 'hospital hopper' with the ability to induce asthmatic attacks severe enough to warrant hospital admission, and who was known to several other hospitals throughout the country.

What is the position of the professional with regard to the use of a Place of Safety Order in such a case? Clearly there is no problem when there is no doubt that the client is anything other than the given age, but where there is doubt, as in this case, it would seem prudent to inform the Magistrate of one's suspicions and let him make up his own mind. Interestingly, there is no reference to this situation in the Children and Young Person's Act 1969, the Children's Act which is due to come into effect next year, or the legal literature. As to whether an adult subjected to a Place of Safety Order would be able to sue the applicant for wrongful detention, such action would be unlikely to be successful since the subject had deliberately placed himself in a position where detention was likely, and the applicant had acted "in good faith".

The suggestion that there should be a central register of Munchausen cases has been made before (Markantonakis & Lee, 1988; Jones, 1988). I suggest that such a register include photographs, since a description alone is rarely adequate to identify an individual unequivocally. Rapid access to photographs and data should present no problem as more hospitals acquire fax machines.

I should like to thank Michael Petley of the College of Law for his advice.

ROBERT DAVEY

Clatterbridge Hospital
Bebington, Wirral
Merseyside L63 4JY

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Psychiatric syndromes in literature

DEAR SIRS

As a Belgian-born psychiatrist, I was delighted to read the article by Förstl *et al* (*Psychiatric Bulletin*, December 1990, **14**, 705–707) which draws attention to the description of the Capgras delusion by the late Georges Rémy (better known under the pen name Hergé). Although the phenomenon's origins have been traced to classical myths (Christodoulou, 1986), the clinical features were first delineated by Kahlbaum (1866), more than 50 years before the report in 1923 by Capgras and his assistant, Reboul-Lachaux. Recently, it has been argued that the interest in delusional misidentification of French psychiatrists in the 1920s was sparked off by a popular series of novels depicting the exploits of the criminal Fantômas, who could assume the appearance of others!

A fascinating description of the Capgras delusion, from the patient's point of view, can be found in the autobiography of Clifford Beers (1908), founder of the American mental hygiene movement. During an episode of psychotic depression, Beers became convinced that friends and relatives had been replaced by sinister impersonators. As the depressive symptoms resolved, so did the Capgras phenomenon and the author gained insight into his delusional beliefs.

Another Belgian writer who has given a colourful account of a psychiatric condition is the late Georges Simenon, creator of the detective, Inspector Maigret. Apparently Simenon had once considered becoming a psychiatrist himself but was unable to study medicine for financial reasons, turning to literature instead! In *Monsieur Lundi*, written in 1941 or 1942 but published in 1944, he described a woman suffering from erotomania with the classical and potentially dangerous features delineated two decades earlier by de Clérambault. However, Simenon, who had no compunction about describing his own sexual exploits, does not seem to have been acquainted with the writings of this influential French psychiatrist,

https://doi.org/10.1192/pb.15.3.166-a Published online by Cambridge University Press