necessity to ensure further validation and replication on fresh samples.

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Psychiatric Morbidity and the Mentally Handicapped

SIR: Day (*Journal*, December 1985, **147**, 660–667) reported that 30% of mentally handicapped residents aged over 40 years and 20% of those admitted to a psychiatric day hospital for the mentally handicapped aged over 40 years had a significant psychiatric disorder. This study contains artefacts which lead to an over-estimation of the prevalence of psychiatric disorder.

No information is given concerning reliability. Poor reliability may have occurred at the time of diagnosis, during transcription of diagnoses from case notes, when diagnoses were re-classified into five super-ordinate categories (e.g., into the categories "psychosis" vs "psychosis"), and when diagnoses were made from case notes only (as in 6% of cases).

If the aim of the study was to estimate the current prevalence of psychiatric disorder then the inclusion of people with a history of psychiatric disorder clearly inflates this. For example, people may have previously suffered a single episode of an illness or may have been treated and no longer show the disorder.

Day gives no formal definition of "behaviour disorders" although he refers to examples of this. Whilst some instances of such behaviours have been shown to be associated with specific disorders (e.g., Lesch-Nyhan syndrome) it is not clear what *proportion* of such behaviours are indicative of psychiatric morbidity. Some behaviour disorders are associated with painful physical illness such as otitis media, undetected dental abscesses and chronic nasal infection. Others may be considered examples of learned behaviours. Behaviour disorders are clearly of heterogeneous origins and only some are psychiatric in nature (Jacobsen, 1982).

Finally, Day includes a number of offensive and troublesome behaviours as psychiatric morbidity. These include behaviours such as wandering, stealing, and public masturbation. Such problems may not reflect psychiatric morbidity in all cases but a variety of other problems such as lack of privacy, poor learning history or an environment which maintains aberrant behaviours.

Behaviour disorder accounted for 50.5% of psychiatric disorders in the long-stay residents and 35.5% of the day hospital admissions. If a substantial proportion of these could not be demonstrated to be psychiatric in nature then the prevalence of psychiatric morbidity would fall substantially.

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The Effect of Sulpiride on Negative Symptoms of Schizophrenia

SIR: Activating or disinhibitory effects of neuroleptics given in low doses to patients with schizophrenia were described when these drugs were first introduced to psychiatry (Delay *et al*, 1957), but subsequent experience with conventional anti-psychotic drugs has failed to provide convincing evidence of a useful dose-related bipolarity of effect. From the time of its original use in psychiatry, however, subsidiary effects of sulpiride – described in a variety of terms such as "anti-autistic" or "thymo-analeptic" have repeatedly been noted (Collard, 1969), and neuropharmacological studies (Sokoloff *et al*, 1980; Brown & Arbuthnott, 1983) suggest sulpiride may show a clinically useful separation of dose-related effects on psychiatric symptoms, low doses having activating and/or antidepressant properties, while higher doses are effective against positive symptoms of schizophrenia.

Since there are no controlled studies in this area, we have undertaken a double-blind comparison of normal versus low dose sulpiride in patients with chronic schizophrenia characterised predominantly by the negative symptoms poverty of speech and flattening of affect.

Six women and 11 men, aged 18 to 35 (mean = 27), with a diagnosis of schizophrenia according to Feighner's diagnostic criteria for 2 to 12 (mean = 7) years, and complying with Wing's 1961 criteria for negative symptoms, were randomly allocated on a double-blind basis to treatment with sulpiride at a dose of either 50 mg ($n = 9$) or 400 mg ($n = 8$) three times daily. All patients completed 30 days, and 12 (low dose $n = 7$, normal dose $n = 5$) completed 60 days of treatment.

Brief Psychiatric Rating Scale (BPRS) and Clinical Global Impression (CGI) scores were obtained at standard intervals during the course of the study, and the patients were examined daily for side-effects. Prior to the study, two patients had never had drug treatment, and the remainder had received no drugs for a mean of 82 days (range 7–540).

Only the low dose patients underwent significant improvements, both clinically and statistically. At 30, 45, and 60 days the BPRS mean total had decreased significantly from the Day 1 value, and analysis of symptom scores showed this improvement was due mainly to a fall in the portion of the total score contributed by the items 'emotional withdrawal' and 'blunted affect', i.e. the negative symptoms. After 30 days' treatment, mean 1200 mg versus 150 mg dose negative symptoms sub-totals were 10.5 vs 7.7 (Day 1 scores 10.8 vs 9.7), *t*-test (2-tailed) between changes of each score from Day 1 significant at $P < 0.01$; after 60 days, 10.0 vs 2.7, $P < 0.01$. The CGI, which would have been largely determined by the predominantly negative symptom profile of each patient, showed a similar result of significant improvement from Day 30 onwards restricted to the low dosage group. Two patients on normal dosage experienced an episode of acute dystonia at the start of treatment, which resolved spontaneously; there were no other significant side-effects.

Full details of the study are being submitted for publication. However, in recent years, particularly as a result of the work of Johnstone *et al* (1978) on the isomers of flupenthixol, it has been considered increasingly likely that the beneficial effects of conventional neuroleptics are restricted to positive symptoms (delusions, hallucinations, and thought disorder) of schizophrenia, and we think this result with an atypical anti-psychotic drug is of interest.

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Allergic Type Response to Trazodone

SIR: Trazodone is a triazole pyridine derivative unrelated in structure and pharmacology to the tricyclics, tetracyclics and monoamine oxidase inhibitors. It has been associated with dermatological reactions including erythema multiforme (Ford & Jenike, 1985) and leukocytoclastic vasculitis (Mann *et al*, 1984). We wish to report what appears to be a previously undescribed reaction.

Case report: C.M. is a 52-year-old male executive with a history of myocardial infarction in 1972 and 1983. He underwent triple bypass surgery in 1984 and has been physically well since. Six weeks prior to presentation he was involved in a minor road traffic accident with no physical injuries. He began to complain of persistent anxiety, marked insomnia, loss of confidence, lethargy, social withdrawal, irritability, loss of interest in his job, and consistent depression with diurnal variation. He had no previous personal or family history of psychiatric disorder. A diagnosis was made of a depressive anxiety state precipitated by a traumatic episode. In view of his cardiac status he was commenced on trazodone (50 mg t.i.d.). He was on no other medication. Within 24 hours he noted swelling of the index finger of his right hand and within a further 24 hours both his hands became markedly swollen to the extent of his being unable to make a fist. He reported this to the local casualty officer but neglected to mention that he was on medication. Observation was advised and no medication was prescribed. He continued to take trazodone and within a further 24 hours both his feet and legs developed significant swelling. He also complained of a generalised throbbing headache. At this stage he discontinued the trazodone and his symptoms totally resolved over the next 48 hours. He reported this condition on follow-up. In view of his cardiac condition he was not challenged again with trazodone.

This pattern of clinical presentation and resolution with cessation of the drug indicates that the symptoms were directly related and is suggestive of an allergic type response.