scientific process is dismissed. Normally, a null hypothesis is formulated and data is collected to reject this null hypothesis. Sherlock Holmes may be excused his position because tests of significance and modern hypothesis testing had not been developed in Conan Doyle's day, but there is no such excuse for Dr Johns.

Secondly, Dr Johns sweeps aside the practice of making assessments of both fictional and historical figures, and states that if such assessments lead to a diagnosis, it "is to severely debase the term". On the contrary, it is perfectly legitimate to consider the maladies of such personages. The medical and literary world would be impoverished if discussion of Beethoven's deafness or Hamlet's madness were dispensed with. In addition, Dr Johns has a particularly narrow view of literature when he says, "Our appreciation and enjoyment ... are not increased by psychiatric post-mortems". Indeed, one of the purposes of literature is to encourage us to think, and I wonder if Dr Johns is familiar with the myriad volumes written on literary criticism, much of which deals with psychological issues and which by its very nature is a 'post-mortem'.

Sherlock Holmes may well show features of obsessional neuroticism, and Dr Rollins adduces convincing textual evidence to support his case. Dr Johns' comment that "He complained of no mental illness" is insufficient to disprove Dr Rollins' interpretation. It is well known that there are those who have psychiatric symptoms but deny them, and so the concept of insight seems to have escaped Dr Johns.

Not only are Dr Johns' arguments flawed but so also is his English. As an example, the following sentence defies comprehension: "Lest anyone thinks I am unduly critical of a pleasant literary piece, the Sunday Times of 21 August commented on the article under the headline 'He was quite a case' ". It is clear that Dr Johns would benefit from a greater study of the arts not only to elicit a more mature response to literature, but also to improve his English.

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## CT Studies of Schizophrenia

SIR: The interesting findings of Smith *et al* (*Journal*, 1988, **153**, 667–674) stimulated me to look at our computerised tomography (CT) findings in the context of the influence of different control-matching in our patient subsamples.

We examined 150 RDC-diagnosed chronic schizophrenic patients from mental hospitals with CT (Mundt, 1985). Due to personnel problems we had to carry out the CT scans in two different centres: group 1 (71 patients) was examined at the Surgical University Hospital, Heidelberg, and group 2 (73 patients) in the Central Institute of Mental Health, Mannheim. Among the CT measures taken were the III ventricle diameters, the cella media index, and the number of enlarged sulci. For both groups of patients, control groups were recruited as coupled pairs matched for sex, age, and skull diameter. The controls for group 1 were taken from the Medical University Hospital, Heidelberg; those for group 2 from selected physically healthy neurotic patients at the Central Institute Mannheim. We used identical restricted exclusion criteria for both control groups. The results of a comparison within the matched pairs differed between the groups: group 1 displayed no significant differences whatsoever between patients and controls; group 2 showed slightly but significantly larger III ventricles in the schizophrenic patients than in the controls.

In order to better understand this inconsistency we used the following procedure: first we compared group 1 and group 2 patients according to age and sex distribution; no difference was found. Then we calculated a correction for the matrices of the two CT scans, and corrected all the values for the III ventricle diameters in group 1 and group 2 for both the patients and the matched controls. It turned out that the inconsistency was due to the very different values of the controls; the values for groups 1 and 2 are close, and lie between those for the two control groups. We found that the controls from the Medical Hospital showed larger ventricles than the selected control group of physically very healthy neurotics from the Central Institute.

These results raise the question of which control-sampling can be considered to be most adequate for a group of chronic schizophrenic patients. Obviously we know little about non-illness-related factors which may influence the width of the III ventricle and other CSF spaces and so contribute to the considerable variance of these measures in the general population.

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