patient's mental state still precluded informed consent and so PEG was implemented under Section 62 as a life-saving procedure.

The patient started enteral feeding under the guidance of the hospital dietitian. The combination of ECT and PEG-feeding resulted in a marked improvement in her physical and mental condition. She was discharged with the tube *in situ*, the district nurse being educated in how to manage the tube, with CPN and psychiatric review. It was decided that the tube would be removed when she attained a certain target weight of 47 kg, and she achieved this in ten weeks. She is now well at six-month follow-up with no depressive ideas and weighs 49 kg.

Feeding via PEG is increasingly used in the UK for feeding patients after stroke and severe head injury. It has occasionally been used for patients with dementia and depression (Bussone *et al*, 1992). It is a simple technique with a 95% success rate for insertion, procedure times of 15–30 minutes, excellent tolerance by the patients (who are often at high risk from surgical procedure), low morbidity (about 6–16%), and with a low procedure rate related to mortality (0–1%) (Ponsky *et al*, 1985; Larson *et al*, 1987). The tubes are concealed beneath the patient's clothing and are therefore cosmetically acceptable and less likely to interfere with rehabilitation. This can be used as a safe and effective method for providing long-term enteral nutrition in patients with eating disorders as an adjuvant to definitive psychiatric treatment maintaining effective nutrition while psychiatric recovery takes place.

We believe PEG feeding should be considered for patients with treatable depressive disorders complicated by cachexia as a safe alternative to nasogastric and intravenous feeding.

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CORRIGENDUM

Journal, May 1993, **162**, 672. The first line of the summary should read "First-degree relatives (FDRs) of 162 schizophrenic and 106 control probands were investigated."

A HUNDRED YEARS AGO

A case of melancholia; sudden illness and death

By FRANK ASHBY ELKINS, MBCMEDIN, *Senior Assistant Physician, Royal Edinburgh Asylum*

A man aged forty-five, married, was admitted to the Royal Edinburgh Asylum on May 25th 1889. A sister of the patient had had an attack of mania and had recovered. He had had a precisely similar attack of hypochondriacal melancholia six years before admission, the symptoms not being quite so severe, and after a year's duration he had recovered perfectly and had remained well for five years. He was a thick-featured, fairly well nourished, rather lymphatic man, with a most woeful expression. He affirmed that nearly every organ of his body was diseased, that his bowels never acted, that he was dreadfully weak and ill, and, in fact, that he was dying. Repeated physical examinations always gave negative results. His bowels were only slightly costive, and it seemed evident that he greatly exaggerated his unpleasant sensations. He was, however, sleepless and he had dyspepsia, as was shown by a furred tongue and by very occasional vomiting, the latter being at least once induced by his putting his finger down his throat. Under treatment he at first rapidly improved mentally and gained in bodily weight; he attended and enjoyed the weekly dances, played lively airs upon his violin and seemed a most promising case. Unfortunately a relapse occurred. Not satisfied with two medical visits a day, he used to send letters to me as well. On Feb. 11th, 1890, he wrote: "I endure unsufferable agony; I fear to perish in this terrible state; I entreat you to examine my stomach and bowels." At that time he had gained twenty-one pounds in weight since admission; he slept fairly, his appetite was good, his dyspepsia was better and he

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