WEINER, R. D. (1980) The persistence of electroconvulsive therapy induced changes in the electroencephalogram. *Journal of Nervous and Mental Disorders*, **168**, 224–228.

S. CURRAN

University of Leeds
Leeds LS2 7TF

D. WALLACE

High Royds Hospital
Ilkley, W. Yorkshire LS29 6AQ

REPLY: Well designed studies that control for stimulus intensity do not support the suggestion that bilateral ECT leads to either longer convulsions or cerebral seizure activity measured by electroencephalogram than unilateral ECT (Sackeim *et al*, 1987; 1993). The study by Abrams *et al* (1973) concerned multiple monitored ECT where three or four electrical stimulations were applied about two minutes apart during prolonged anaesthesia and is of uncertain relevance to the contemporary practice of ECT. Weiner (1980) did not report original data to support the suggestion that bilateral ECT leads to longer cerebral seizure activity.

Bilateral ECT with the bifrontotemporal placement is associated with a higher seizure threshold than right unilateral ECT with d'Elia's placement at the outset of treatment and throughout the course of treatment. The original data in support of this statement and possible explanations are given in the reference cited in the accompanying handbook (Sackeim *et al*, 1991).

ABRAMS, R., VOLAVKA, J. & FINK, M. (1973) EEG seizure patterns during multiple unilateral and bilateral ECT. *Comprehensive Psychiatry*, **14**, 25–28.

SACKEIM, H. A., DECINA, P., KANZLER, M., *et al* (1987) Effects of electrode placement on the efficacy of titrated, low-dose ECT. *American Journal of Psychiatry*, **144**, 1449–1455.

—, DEVANAND, D. P. & PRUDIC, J. (1991) Stimulus intensity, seizure threshold, and seizure duration: impact on the efficacy and safety of electroconvulsive therapy. *Psychiatric Clinics of North America*, **14**, 803–843.

—, PRUDIC, J., DEVANAND, D. P., *et al* (1993) Effects of stimulus intensity and electrode placement on the efficacy and cognitive effects of electroconvulsive therapy. *New England Journal of Medicine*, **382**, 839–846.

WEINER, R. D. (1980) The persistence of electroconvulsive therapy induced changes in the electroencephalogram. *Journal of Nervous and Mental Disorders*, **168**, 224–228.

A. I. F. SCOTT

Royal Edinburgh Hospital
Edinburgh EH10 5HF

Late-life depressive disorder

SIR: While Van Ojen *et al* (1995) make use of large numbers of subjects and use the AGE-CAT diagnostic system, which is to be commended, there do appear to be a number of drawbacks to their study.

Firstly, one has to question the validity of MMSE scores of less than 26. This is at best a fairly crude screening tool for evaluating cognitive function. Furher *et al* (1992) conclude their study by stating that functional impairment has "a basic confounding effect on cognitive state" as measured by the MMSE in depression in elderly subjects. The CAMDEX schedule does contain sections relating to functional ability, but in this study, only part of it was used.

Van Ojen *et al* also state that a correlation exists between severity of depressive symptoms and cognitive function, but this was only significant in male subjects in the Furher *et al* study. A further area of concern would be the omission of the prevalence of prescribed medication; 80% of subjects over 65 regularly take prescribed medication, and the effect of this cannot be ignored in relation to cognitive function. Similarly, ethnicity and level of anxiety would also be sources of error in the MMSE.

To assume that depression in old age, in the absence of past psychiatric history, is primarily due to "prodromal" Alzheimer's disease appears to be a gross over-simplification. From the organic point of view Rabins *et al* (1991) demonstrated diffuse subcortical abnormality on the MRI in depressed subjects, but concluded that this was unlikely to be an early dementing process, and that it is likely that there are organic changes specific to depression.

FURHER, R., ANTONUCCI, T., GAGNON, M., *et al* (1992) Depressive symptomatology and cognitive functioning: an epidemiological survey in an elderly community sample in France. *Psychological Medicine*, **22**, 159–172.

RABINS, P., PEARLSON, G., AYLWARD, E., *et al* (1991) Cortical magnetic resonance imaging in elderly inpatients with major depression. *American Journal of Psychiatry*, **148**, 617–620.

VAN OJEN, R., HOOIJER, C., BEZEMER, D., *et al* (1995) Late-life depressive disorder in the community I & II. *British Journal of Psychiatry*, **166**, 311–319.

M. LESTER
M. BLANCHARD

Royal Free Hospital
London NW3 2QG

AUTHORS' REPLY: Among elderly community members, impairments in the functional, cognitive, and effective realm may be entangled. In order to disentangle the interrelationships our research group has recently commenced the analysis of follow-up data describing groups of elderly subjects with either functional or cognitive impairment, depression and anxiety, combinations of these or no

https://doi.org/10.1192/S0007125000066253 Published online by Cambridge University Press

impairments at the base-line interview. The sequence in which the defects are expressed in time may shed some light on the basic mechanisms that underly their co-occurrence.

For our report we have studied the cross-sectional data (base-line interview). We found that a history of a prior impairment in the affective realm singled out a group of elderly subjects. Among these subjects GMS–AGECAT depression was not associated with MMSE scores below 26. Among other elderly subjects these measurements were clearly associated, but the meaning of this relationship remains unclear.

The relationship may suggest that the MMSE impairment does, as a rule, not follow the onset of affective problems in time. Instead, the MMSE-impairment may accompany depressive disorders with a first onset in late life, occurring simultaneously. This conclusion is in line with the results of studies in which an increased rate of brain-scan abnormalities among elderly patients with a late-onset depression has been reported. The combination of late age, depression and mild impairment of MMSE-performance may indicate a specific and possibly organic syndrome that may be different from other cases of late life depression.

As Lester & Blanchard point out, 'prodromal' Alzheimer's disease is only one of the possible explanations. Functional impairment, use of medication, gender, ethnicity or anxiety may also be involved, and exploration of the roles of these variables certainly seems worthwhile.

It would be interesting to study associations of the syndrome with such variables, but also with possible symptoms of depression other than anxiety, social stress-factors and medical diagnoses. Equally interesting may be the course of the syndrome. The course may be chronic or intermittent or a dementing illness may develop. The pathological anatomical abnormalities that may be associated with the syndrome also deserve some attention. These may be similar to those found among patients with Alzheimer's disease, but one would expect the localisation of abnormalities to be different at least.

R. L. VAN OJEN
W. VAN TILBURG

Psychiatric Division of the
Free University of Amsterdam
Valeriusclinic Amsterdam

Keeping count for the community

SIR: Wilkinson *et al* (1995) have provided a service to a catchment area with 14 stable schizophrenic patients living in it. The service consisted of one consultant psychiatrist, one senior registrar, 12 psychiatric nurses, one clinical psychologist, one senior occupational therapist, one senior social worker and two full time equivalent administrative assistants. This is in addition to primary care resources.

In the catchment area for which I am personally responsible I am aware of 180 people suffering from schizophrenia. Our team consists of myself, four-and-a-half-equivalent community psychiatric nurses, one untrained support worker and a half-time equivalent occupational therapist. Should similar resourcing be available to us there would be 12 consultant psychiatrists, 12 senior registrars, 144 psychiatric nurses, 12 clinical psychologists, 12 senior occupational therapists, 12 senior social workers and 24 full time equivalent administrative assistants. I am sure all 228 of us would do a jolly good job but how on earth would I learn all their names.

WILKINSON, G., PICCINELLI, I., FALLOON, I., *et al* (1995) An evaluation of community-based psychiatric care for people with treated long-term mental illness. *British Journal of Psychiatry*, **167**, 26–37.

M. BLACKWELL

Greenwich District Hospital
Greenwich SE10 9HE

Severe apathetic hyperthyroidism with normal thyroid hormone levels

SIR: "Subclinical" hyperthyroidism (suppressed TSH secretion in the presence of normal thyroid hormone levels) is associated with an increased rate of physical and psychiatric complaints resembling those seen in overt hyperthyroidism (Scholte *et al*, 1992) and of other complications such as atrial fibrillation (Sawin *et al*, 1994). Severe apathy is well recognised as an uncommon complication of overt hyperthyroidism, but to our knowledge it has not previously been reported in a patient with normal circulating thyroid hormone levels.

Case report. A 62-year-old woman with a previous history of manic-depressive illness was admitted to hospital with a 5-month history of inactivity and progressive self-neglect. When she first became inactive the neuroleptic she was then receiving was discontinued but she deteriorated further and a presumptive diagnosis of depression was made. She did not comply with antidepressants and was admitted under the Mental Health Act in a dirty and neglected state with untreated infections of her eyes and urinary tract, and infestation with head lice. After admission she was profoundly apathetic, with

https://doi.org/10.1192/S0007125000066253 Published online by Cambridge University Press