to 2.4 s at pulse rate of 70 Hz. Impedance was controlled through the Thymatron impedance meter.

There were only seven missed seizures out of 557 treatments (1.2%), while no patients showed a complete inability to convulse during each ECT session. One patient only showed more than one missed seizure for the session (two out of four). The energy we delivered is considerably lower than that reported by Freeman and Pippard & Russel, and this discrepancy could be explained in terms of the critical electric parameter of the stimulus waveform. The superiority of the brief-pulse waveform compared with the sine wave form in terms of efficacy has been well documented in a number of controlled studies (Weaver *et al*, 1977). In fact, a square wave delivers all of its energy above the threshold, whereas the sine wave delivers substantial amounts of below-threshold energy (Maxwell, 1968). The consequence of this is that all the energy delivered (without dispersion) is valid to induce seizure.

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Spontaneous orgasms – an explanation?

SIR: Al-Sheikhli (*Journal*, August 1989, **155**, 269–270) reported a case of spontaneous orgasms in a 45-year-old lady in the absence of gynaecological, hormonal, or overt psychological disturbances and asked for an explanation for the phenomenon. The next step in management should be a careful search for organic brain disease. Lishman (1978) cites a case where a hemangioma of the medial surface of the sensory cortex caused similar experiences localised to the contralateral side of the vagina (Erickson, 1945). This lady's symptoms occur in a transient, episodic, recurrent fashion, which is the basic format of most epileptic disorders. Skull X-ray, an EEG and a computerised tomography scan could help to rule out structural pathology causing secondary electrical changes. A trial of antiepileptic medication seems worthwhile, even in the presence of an apparently normal EEG. This basic 'organic work-up' is essential before any psychological avenues are explored.

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Pseudodementia

SIR: Howells & Beats (*Journal*, June 1989, **154**, 872–876) describe an intriguing case with partial recovery, to which we should like to add our own experience.

Recently, for the first time in the 10-year history of our unit, we have admitted several unusual cases of 'pseudodementia'. These were four females with florid illnesses, unknown to each other, and admitted at different times. Two were married, one had been living with a common law husband, and one was recently widowed. Three were Canadian born, and one was a West Indian immigrant. Ages ranged from 70 to 80 years. Previous history consisted of a discrete episode of depression, 30 years earlier, in one case and several admissions over 20 years to mental hospitals in other countries, in another. The patients had received ECT. Otherwise there was no history of psychiatric disorder, or drug or alcohol abuse. Histories of the present illness ranged from six months to three years.

The cases presented with bizarre behaviour, varying from frenetic activity and screaming to withdrawal and somnolence. The behaviour varied both between cases and over time. Central to the mental states were dysphoric mood, anxiety, confusion, and Ganser responses. However, only one case approached the level of major affective disorder. All

did badly, initially, on tests of cognition and function. On our unit, which acts as a tertiary referral centre, examinations by psychiatry, internal medicine, neurology, neuropsychology, EEG and brain imaging did not show irreversible dementia. Sodium amytal interview proved valuable in one case with the person temporarily reverting to normal; it was contraindicated in two cases on medical grounds, and one patient became extravagant but remained confused. In hospital the four patients were assumed to have an atypical depression and were placed a monoamine oxidase inhibitor (MAOI) drug for several months. Two of these patients made a total recovery in hospital, with one remaining well and the other relapsing after discharge; one remained calmer, but confused, on the medication; and the last made no response. Following discharge one remained well, and the other three required chronic care; one to the point where she needed total nursing care as though she suffered from an irreversible dementia.

What we call this syndrome is a moot point. Hysteria or Briquet's syndrome is a complex matter and readily misdiagnosed (Slater, 1961, 1965). It is often thought to be associated with being young or unsophisticated to the point that Brody (1985), in a discussion of our ageing society and changing illness patterns, wrote that " 'conversion hysteria', one of Freud's most frequent diagnoses, seems to have vanished". Kiloh (1961), in emphasising the need for vigilance with depressive pseudodementia, took pains to distinguish it from the hysterical variety. Whitlock (1982) cautioned that the Ganser syndrome of approximate answers may be wrongly equated with a hysterical form, since Ganser did not think that his patients feigned illness. Ganser symptoms are much more common than the syndrome and occur across psychiatry. Lastly, Bulbena & Berrios (1986), in a thorough survey of the topic, questioned the existence of hysterical pseudodementia.

In our group there seemed to be an interaction between anxiety, dysphoric mood and possibly personality and marital relationships. Merely calling the cases depression, or depressive pseudodementia, did not do justice to the clinical picture. The two married ladies did seem dependent. However, they found their husbands controlling, an opinion shared by the ward staff. Neither of these women improved lastingly. Improvements took place in the recently widowed and the previously common law wife. The widow was ambivalent about her marriage, which had not been happy. She continues to do well after one year on phenelzine.

In summary, our four cases are a mixed bunch. The best result was achieved with the lady with the shortest history, who seemed to benefit from phenelzine and widowhood. Sodium amytal interview was not given in her case due to medical contraindications, but proved useful in the other successful MAOI-treated, albeit relapsing, case.

The group exhibited a kind of pseudodementia. This is based on negative findings on investigation and some response to sodium amytal interview and an MAOI drug. The ultimate prognosis is uncertain but generally, in the short term, is grim. The explanation is unclear but the role of unsatisfactory marriages, even lengthy ones, has to be noted. All geriatric psychiatry units need to be aware of these cases and the need for a standard protocol in their assessment and treatment.

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Beclomethasone mania

SIR: In his study of mania in the elderly, Stone (*Journal*, August 1989, **155**, 220–224) suggests that cerebral organic impairment will be increasingly recognised in a multifactorial aetiology. The following case of an unusual drug reaction supports this view.

Case Report: In November 1988 a 69-year-old man had a two-month manic illness. This followed a course of oral prednisolone (reducing from 20 mg/day) for obstructive airways disease. There was no family or previous psychiatric history, and a diagnosis of steroid-induced mania was made. He recovered two months after the onset.

In April 1989 he again developed mania three weeks after starting Beconase (beclomethasone dipropionate) nasal spray for allergic rhinitis. It is suspected that he took twice