mechanisms. But differentiating the function and characteristics of particular types of social relationships is equally important for discriminating the variety of disorders. For example, an inability to experience intimacy is experientially and clinically different from an inability to experience security within an intimate relationship. The first we would term a disorder of the affiliative system; the second, of the attachment system. To attempt to 'circumvent' these distinctions hinders rather than aids conceptualisation in this field of research.

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Zinc in Senile Dementia

SIR: I wonder why Ken & Gibb (*Journal*, August 1986, **149**, 221–223) chose patients in their comparison group who were suffering from disorders in which low zinc levels have been reported. Srinivasan (1984) reviews psychiatric disorders in which low zinc levels occur: these include affective disorders, confusional states, and schizophrenia, all of which were included in the comparison group. The study would have been more valuable if a comparison had been made with a healthy, non-psychiatrically ill control group who were matched for age and sex with the dementia group, and it is possible that low zinc levels in dementia could then have been demonstrated.

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49 Chromosome Anomaly

SIR: We describe another patient with 49 XXXXY anomaly (*Journal*, February 1986, **148**, 209–210 and 210–212).

Case report: A male, aged 34, has been an in-patient for the last 22 years. He was born with the cord around his neck and was cyanosed at birth. His developmental milestones were delayed. He had recurrent chest infections as a child. His mother was 34 and his father was 39 years old at his birth, and he is the youngest of three siblings.

On physical examination, he is 5 ft $\frac{3}{4}$ ins in height and his head circumference is $52\frac{1}{2}$ cm. He has a small face, with palpebral fissures slanted upwards and outwards. He is severely myopic, and has left-sided club foot. He has a narrow chest and does not have any facial or body hair, although he does have a few axillary and pubic hairs. His penis is small and his testes are undescended. He had phymosis at birth, which has been operated on in the past.

He is passive, friendly, and attention-seeking, and has a high-pitched voice. He likes music, discos, and parties and is also interested in swimming. He is fully ambulant and his self-help skills are good. He is able to read and write. His IQ was tested in 1981, when the WAIS score was 60. He had unexplained recurrent falls in 1983, and an EEG showed bilateral cortical dysfunction maximal over temporal regions. He had no more falls after he was started on carbamazepine.

It is interesting that despite 49 XXXXY anomaly and some perinatal damage this patient is functioning at the level of mild-to-moderate mental handicap.

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Post-ictal Syndrome after ECT

SIR: James & Simpson (*Journal*, September 1984, **145**, 337–338) invited comment on the observation of a second spontaneous fit after the second ECT given to a young woman suffering from a psychotic depressive illness associated with refusal to eat or drink.

Recently a similar observation was reported locally. A 24-year-old woman suffering a depressive illness had received a 12th right unilateral treatment. The treating doctor reported that about a minute after a tonic-clonic seizure she displayed further arm and leg movements lasting approximately 30 seconds, and concluded that she had undergone a second epileptic seizure.

By chance the young woman was taking part in a study, and thus a 4-channel EEG recording was

made of her treatment by an independent observer. The recording showed a clear synchronous centrencephalic spike and wave episode lasting 54 seconds immediately after electrical stimulation. Thereafter the recording showed diffuse slow activity, often in dysrhythmic runs. Approximately 45 seconds later there was a return of muscle potentials on the record, and a period of small muscle twitches and movements were seen. However, there were no further concomitant cerebral epileptic events after the initial grand mal fit. The recording continued for 380 seconds after electrical stimulation.

Motor restlessness and uncoordination are recognised features of the post-ictal syndrome (Livingston *et al*, 1980). In the absence of any epileptic phenomena on the EEG this seems a more likely explanation than that she experienced a second seizure.

The difficulty of differentiating by observation alone the motor restlessness of a post-ictal syndrome from a second epileptic seizure may not, of course, necessarily explain the clinical phenomenon observed by James & Simpson. Certainly, if spontaneous second seizures are to occur, they would be expected to occur early in treatment as the fit threshold rises during a course of ECT (Sackeim *et al*, 1986). If a second seizure occurs after ECT, it is important to consider possible precipitants such as drugs with convulsant properties, e.g. tricyclic antidepressants and phenothiazines. The woman in the reported case was drug-free, and thus we wondered about other precipitants such as hyperuraemia or menstruation (Hopkins, 1983).

The value of routine EEG monitoring of ECT is a matter of dispute, but it is unlikely that such clinical phenomena will be understood properly without simultaneous EEG monitoring.

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Difficulties in Assessing Tardive Dyskinesia

SIR: Tardive dyskinesia (TD) is a major side-effect of long-term administration of neuroleptics. It is important therefore that its incidence, prevalence, and response to treatment are accurately determined. Such accuracy, however, is bedevilled by difficulties in assessment, and we report a further example of this difficulty.

As part of an (unpublished) open study of the efficacy of a novel psychotropic drug (Glaxo, GRC507/75) in the treatment of TD, ten chronic schizophrenic in-patients with TD were assessed before treatment using the Abnormal Involuntary Movements Scale (AIMS) (US Department of Health, Education and Welfare, 1976) and immediately afterwards were videotaped for one and a half minutes in a standardised way (Kidger *et al*, 1980). The live and video ratings were made by two different psychiatrists; the video rater was unaware that the ratings were before treatment.

As assessed by the AIMS global rating, six patients had mild and four moderate TD; two patients on video had no evidence of TD. The AIMS subscale found that all patients had orofacial and five distal dyskinesia, while the video ratings found only six with orofacial and four with distal dyskinesia.

Videotaping of patients with TD has obvious advantages, especially when carried out serially, as the order of presentation to the rater can be randomised. The present results suggest, however, that it may be less sensitive in mild and moderate cases than the more detailed assessment by AIMS of the 'live patient'. Indeed, our impression was that patients 'froze' in front of the camera. The main drawback to the AIMS is that it does not allow for a quantitative assessment of frequency, amplitude, or duration of movements (Barnes, 1984).

Agreement between live and video ratings was higher in two previous studies (Barnes & Trauer, 1982; Firth & Ardern, 1985). In the former study, however, the patients were unaware of the reasons for videotaping; in the latter, at least one movement was rated 'moderate-severe' in the Abbreviated Rockland Rating Scale. However, evaluation of methods of treatment must focus on patients with mild TD who give informed consent to the study.

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