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PREMENSTRUAL SYNDROME

DEAR SIR,

Anthony Clare's (*Journal*, January 1981, **138**, 82–83) reservations about sine wave fitting to daily recorded symptom scores to assess and diagnose 'premenstrual' tension, and his preference for a polynomial fit and F test, set us to work on that comparison. We concluded that Gödel's premenstrual hypothesis might have been as follows. To use statistics in this field you require a null hypothesis, which is a formal definition of the mathematical way the symptoms must be temporally related. But, whatever axioms you choose, there will be examples which will fit your formal definitions but not fit your clinical meaning, and vice versa.

A polynomial or harmonic analysis of enough terms will completely represent any time series, but how many terms have any clinical meaning? A sine wave is a crude representation of data from a menstrual cycle, as is a straight line of much other clinical data. However, the sine wave implies a more appropriate approach to a periodic phenomenon than a polynomial function, and the equation's constants have approximately meaningful clinical significance. The struggle for a more completely objective analysis may be commendable yet questionable.

F. A. JENNER
G. A. SAMPSON

Royal Hallamshire Hospital,
Glossop Road,
Sheffield S10 2JF

INTERMITTENT PIMOZIDE IN CHRONIC SCHIZOPHRENIA

DEAR SIR,

I read Dr McCreadie and his colleagues' recent paper (*Journal*, December, 1980, **137**, 510–517) with great interest. Although it is cost saving, intermittent antipsychotic medication ('drug holiday') may be hazardous. Dr McCreadie rightly pointed out that tardive dyskinesia can be precipitated by "drug holiday". There may also be relapse of schizophrenia, which is sometimes called dopaminergic supersensitivity psychosis (Chouinard and Jones, 1980), as well as physical complications (Kitamura, 1976) as a rebound phenomenon.

If, on the other hand, four-day-a-week medication is recommended *because* of pimozide's half life as long as 50 hours, then why not prescribe pimozide once every other day?

TOSHINORI KITAMURA

Department of Neuropsychiatry,
School of Medicine,
Keio Gijuku University,
Tokyo, Japan

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MONOSYMPTOMATIC DELUSION TREATED WITH BEHAVIOURAL PSYCHOTHERAPY

DEAR SIR,

May I comment on the paper by Beary and Cobb (*Journal*, January 1981, **138**, 64–66).

A patient may present with the idea that he smells (when this is not objectively the case) in a variety of different psychiatric syndromes. The symptom can occur in certain sensitive personality developments as an over-valued idea which may dominate the patient's whole psychic life. It is also sometimes seen in depressive illness as a delusion-like idea secondary to the morbid affect, in attenuated schizophrenic illness (or monosymptomatic hypochondriacal psychosis) as a delusional belief, and rarely in organic psychosyndromes. We are only given cursory clinical details of one of the three patients mentioned in the above paper, so that it is difficult to be satisfied regarding the underlying diagnosis in all three. The psychopathology of delusion is all important here. One's confidence is not helped by their woolly comment "avoidance behaviour may reinforce delusional thinking, as often happens in obsessive compulsive and phobic neurosis". Delusions do not occur in obsessional neurosis. I am not arguing that their patients were not deluded, simply that the reader needs more information to be satisfied.

My main contention, however, is with the conclusion "mono-symptomatic delusion is now a treatable condition". They report that two of their three patients improved regarding everyday behaviour, but in both the "delusion" persisted albeit with "reduced

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