objective mood and the associated behavioural manifestations. Others extend the time span to cover a period of up to 24 hours and also comment on the diurnal variation of mood. Some go further to include disturbances of sleep and appetite and even changes in body weight, the latter usually not occurring over a few days. This leads to a blurring of the boundary between the history of the illness and the MSE and raises the question as to how much of the history should come into the MSE. This discrepancy may not be dangerous in routine patient care, but it does cause considerable anxiety and confusion in the candidate sitting the MRCPsych clinical examination. We would like to hear the opinion of the College in this regard.

O. THACHIL
New Town Branch, Worcester Royal Infirmary, Worcester WR5 1JG
S. MIRZA
Lister Hospital, Stevenage, Herts SG1 4AB
P. DE VRIES & A. MICHAEL
Addenbrooke's Hospital, Cambridge CB2 2QQ

Sir: The method employed in the examination of the mental state is clearly dependent upon psychiatric training and orientation. I believe that your correspondents realise that their query is likely to provoke a variety of replies. However, I do have views on the matter, although I would not claim that these should prevail on the MRCPsych examinations and they certainly do not constitute the official opinion of the College.

If the MSE is the precise analogue of the physical examination it would apply on to the findings at the time of the examination. This would often be unsatisfactory as many psychiatric symptoms are not continuously present even in patients seriously unwell. As your correspondents say, it is common practice to ask patients about their symptoms in the previous 24 hours. Diurnal variation in psychopathology is an important aspect of the mental state and clearly requires enquiry about symptoms during a 24-hour period. I would not regard enquiry about bodily functions as falling into the examination of the mental state, but into the 'history of the present complaint'. However, one must not be too dogmatic or rigid, for example, it is relevant to enquire of the patients' frame of mind when they are lying awake following early wakening. In this context it is worth remembering that the way in which information is collected should be acceptable to the patient; the way information is ordered and considered, and the way it is presented to others is a matter for the psychiatrist.

Your correspondents refer to "the subjective and objective mood and the associated behavioural manifestations". I find this confusing as 'behavioural manifestations' are to me the 'objective' manifestations of mood. Mood itself I regard as entirely subjective; the task of the psychiatrist is to enable the patient to describe what may be unfamiliar and perplexing emotions in words with which they are familiar.

Examinees should develop a sound technique for the examination of the mental state and be prepared to defend their approach to the examiners.

R. H. S. MINDHAM
Chief Examiner, The Royal College of Psychiatrists

Psychiatry in Russia – anyone interested?

Sir: I am pleased that the need for increased international links with Russian psychiatry was recently highlighted (*Psychiatric Bulletin*, November 1995, **19**, 703). It is very important that the effects of past isolation and current economic problems on Russian psychiatry are overcome as soon as possible. For the last four years I have been closely involved with a small group of other interested British psychiatrists in developing professional links between the two countries in the field of forensic psychiatry (Gordon & Meux, 1994) and, to a lesser extent, in other psychiatric subspecialities and branches of medicine. Just as British psychiatry was involved in strongly commenting upon past unacceptable practices in Soviet psychiatry we must now be in the vanguard of influencing positive change. I am currently the Project Leader of a British Council funded project to further develop links. A series of exchange visits have occurred involving over twenty personnel from various regions of Britain and Russia including numerous institutions ranging from hospitals of different levels of security to research institutes, medical schools and prisons. Vital provision of information and sharing of experience during these visits has occurred and facilitated attendance at relevant Conferences in each other's countries, publications in each other's journals (e.g. Kachaeva, 1995), exchange of books and journals and the commencement of research collaboration. A psychiatrist from Moscow last year completed the international Diploma in Forensic Psychiatry course organised by the Institute of Psychiatry and other disciplines have also been involved.

Current collaboration is occurring in the areas of training and education, clinical practice, service provision and research. I hope that, subject to continuing financial sponsorship, the links can continue to develop. The mutual trust that now exists smooths the bureaucracy involved and I have frequently been the first

Westerner to visit often sensitive institutions. Although I am aware of some professional colleagues who are involved or keen to develop links with Russia (or indeed other states of the former Soviet Union (e.g. Jacoby & Oppenheimer, 1994)), I would be pleased to hear directly from motivated others so that the most effective and coordinated strategy can develop to maximise the funding and contacts available. The issues are fascinating and the welfare of huge numbers of patients is at stake.

GORDON, H. & MEUX, C. (1994) Forensic Psychiatry in Russia: a renaissance? *Journal of Forensic Psychiatry*, **5**, 599–606.

JACOBY, R. & OPPENHEIMER, C. (1994) A visit to Byelorus. *Psychiatric Bulletin*, **18**, 170–172.

KACHAEVA, M. (1995) Russian literature and psychiatry. *British Journal of Psychiatry*, **167**, 403–406.

CLIVE MEUX
Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF

Antidepressants and breast-feeding

Sir: The paper by Duncan and Taylor (*Psychiatric Bulletin*, September 1995, **19**, 551–552) regarding the use of antidepressants in breast-feeding mothers is a timely reminder of the need for judicious prescribing for these women, and highlights the paucity of published advice. A previous review (Buist *et al*, 1990) reviewed the meagre literature on this topic, and described special pharmacokinetic concerns affecting the infant, including erratic absorption, fluctuating plasma protein binding and reduced capacity to metabolise and excrete drugs. Unfortunately most drug data sheets unhelpfully recommend their use only 'where potential benefits outweigh possible risks', and inform that safety in lactation has not been established.

It can be recognised, however, that specialist centres have generated a wealth of experience in prescribing for this group, and this is so in North Staffordshire where lofepramine is the drug of choice for depression in breast-feeding mothers at the Charles Street Mother & Baby Unit. Lofepramine is a noradrenaline reuptake inhibitor, and meta-analysis studies have confirmed that it is at least as effective an antidepressant as other tricyclics. In common with other antidepressants, it is crucial to remember that hepatic and renal problems in the breast-fed infant are contraindications; lofepramine has been implicated as a rare cause of liver disorders and hyponatraemia in adults.

Duncan and Taylor draw attention to the suggestion that tricyclics with a short half-life are less likely to pose a risk of accumulating drug levels in the infant. Lofepramine also compares well in regard to this pharmacokinetic point, with a half-life of as short as 1.6–5.0 hours, compared to imipramine (8–16 hours) and amitriptyline (32–40 hours). *In vitro* studies indicate that lofepramine shares at least three metabolites with imipramine, and has a further three unique ones. Desipramine is an active metabolite common to both imipramine and lofepramine, and is about five times as toxic as lofepramine with a half-life of approximately 8 hours. However, it has been noted that the ratio of didesmethylimipramine to desipramine is higher in lofepramine metabolism compared to that of imipramine, and is a possible reason for its safer therapeutic profile (Strandgarden & Gunnarson, 1994).

Lofepramine is thus well tolerated because of mild anticholinergic effects, while low cardiotoxicity secures an improved risk: benefit ratio due to its relative safety in overdose, with safer prescribing to depressed out-patients who may also have small children.

We believe there is a need for wider sharing of empirical clinical expertise in the absence of substantive guidelines, and recommend that lofepramine be considered the first-line tricyclic treatment of depressive illness in nursing mothers in preference to imipramine and amitriptyline.

BUIST, A., NORMAN, T. R. & DENNERSTEIN, L. (1990) Breastfeeding and the use of psychotropic medication – a review. *Journal of Affective Disorders*, **19**, 197–206.

STRANDGARDEN, K. & GUNNARSON, P. O. (1994) Metabolism of lofepramine and imipramine in liver microsomes from rat and man. *Xenobiotica*, **24**, 703–711.

K. R. NICHOLLS
West Midlands Rotation
J. L. COX
Keele University

Learning difficulties or mental retardation?

Sir: After reading an advertisement for a book entitled *Dyslexia and Other Learning Difficulties*, published by the Oxford University Press, I picked up my copy of the June 1995 issue of the *Psychiatric Bulletin*. On page 19, I noticed a review of a report on "Sexual Abuse and People With Learning Difficulties", by Katie Drummond, who is associated with the Division of Psychiatry of Disability of the St George's Hospital Medical School. This is followed by a review of a document on the prevention and treatment of sexual abuse of adults with 'learning disabilities' in residential settings.

The above terminology may have the virtue of being politically correct, but it is extremely confusing and does not lend itself to the clear description of clinical entities. Is there any good reason why British psychiatrists and the *Bulletin*