syndrome as a nosological entity in its own right remains somewhat questionable, its occurrence in classical form is sufficiently distinctive to justify the retention of the eponymous term. This particular case was of interest from several points of view. It departs, to some extent, from the classical syndrome in that, although Mr. P. undoubtedly existed and the patient had seen him on two occasions, she had made no further attempts—apart from the one frenzied enquiry at the local hospital—to get into physical contact with him and had seemed quite content to continue with her 'mystical union' until, 'in the Lord's good time'—to use her own words—he would openly declare his love for her.

The relative contributions made by heredity and by environment to the clinical picture were particularly well demonstrated in this patient's illness. Both her sister and a maternal aunt had suffered psychotic breakdowns of paranoid type in the past—the former after attending a particularly vivid 'hell fire' sermon at her local church, and the latter in her senium. Both had responded dramatically to antipsychotic treatment and it seems reasonable to suppose that the patient herself had a genetic predisposition to psychotic, rather than neurotic, illness. The precise form of her illness and its delusional 'content' were pathetically obvious from her early history. A narrow and somewhat puritanical childhood and a restricted and sexually inhibited adolescence had been followed by many years of social and emotional isolation. Her only outlets had been her frequent attendance (with her mother) at their local Evangelical church; here both had developed a somewhat bigoted and intolerant attitude towards those who did not share their convictions or whose daily lives fell short of the rigid standards the couple had set for themselves. Against such a background it is not difficult to understand the breakdown of a vulnerable defence system and the 'eruption' into consciousness of long repressed desires.

Within a week of the patient's admission to hospital her mother lost all her induced delusions and accepted without question that these had been the product of her daughter's disturbed mental state. Up to the time of writing the patient, despite some six weeks of intensive antipsychotic therapy, remains unconvinced of their falsity although more willing now to concede the possibility that she may have been a little 'over-imaginative' on some points.

With the revolutionary socio-cultural changes that have taken place in the Western world over the last half century coupled with the far greater freedom of expression in sexual matters now enjoyed by young people it seems likely that this particular syndrome will become an even greater rarity that it is at the moment.

ARNOLD PEARCE.

Park Prewett Hospital,
Basingstoke,
Hants.

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FATAL HEART BLOCK AND CARDIAC ARREST FOLLOWING ECT

DEAR SIR,

Lest the issues raised by M. O. A. Malik's case report (*Journal*, January 1972, **120**, 69) be clouded, we feel that a few comments regarding J. L. Barton's letter to the Editor (*Journal*, March 1972, **120**, 355) are in order. Barton seems unaware of two lines of evidence. The first is that, to the best of our knowledge, no one has ever been monitoring an ECT with an electrocardiograph when a fatal incident has occurred. Specific cardiac rhythms immediately following treatments that have proved fatal are therefore unknown. The second is that, in the largest published series of monitored ECT (over 1,500 treatments), we have never had anything approaching a life-threatening vagal-induced arrhythmia, and we have exclusively used the subcutaneous route of atropine administration in doses ranging from 0·65 mg. to 2·5 mg. Patient acceptance of subcutaneous atropine, likewise, has never been a problem at this hospital.

Relatively minor changes in treatment technique are not the issues. To rephrase Malik's clearly stated conclusion, proper caution with pretreatment patient evaluation (including an EKG) and proper preparation for rare and unexpected emergencies should always be made.

C. L. RICH.
F. N. PITTS, JR.

Department of Psychiatry,
Washington University School of Medicine,
4940 Audubon Avenue,
St. Louis, Missouri, 63110, U.S.A.

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