electrolytes, and BUN would have given a clearer understanding of this case.

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CIRCADIAN RHYTHMS AND PSYCHIATRY

DEAR SIR,

We wish to offer the following remarks on Christopher Thompson's article on "Circadian Rhythms and Psychiatry" (*British Journal of Psychiatry*, **145**, 204–206). The review does not mention any of the recent studies on the circadian rhythm of melatonin in depression. Research on melatonin rhythm in affective disorders is being pursued actively by many investigators. Wetterberg and his colleagues in Sweden (1982) hypothesised that a low melatonin secretion is a specific neuroendocrine disturbance and may be a genetic marker for affective disorders. Lewy and coworkers (1984) have been studying melatonin rhythm in affective disorders as a marker for human circadian rhythms entrained to light. We share the view of Lewy and have hypothesised that melatonin rhythm in depression is an index of a disturbance of a central pacemaker system which is normally entrained to environmental photoperiod. It is our contention that the diverse dysrhythms in depression may be related to a disturbance in a central neural mechanism. We use plasma melatonin rhythm as a measurable index of its central pacemaker activity, since the stability and usefulness of human melatonin rhythm as a marker has been well established.

Studies on circadian rhythms will be more meaningful when interpreted with respect to a vital entraining cue or Zeitgeber, to infer a true change in their phase (phase advance or delay), rather than when the phase angle between the different rhythms alone is investigated. These have been done using the Phase Response Curves (PRC). PRC's for animals (activity-rest cycles in relation to light) and for man (melatonin rhythm and REM latency in relation to light) have been found to be similar with an advance portion in the morning and a delay portion in the evening (Lewy, 1984).

Our studies (Nair *et al*, 1984) show that under constant and uniform conditions of environmental day length, the depressive patients show a delayed onset of melatonin rhythm compared to matched controls. This raises the possibility that there are at least some depressives who have phase-delayed circadian rhythms. This is supported by Lewy's recent proposition that there may be two subgroups of depressives, with phase-advanced or phase-delayed rhythms (Lewy *et al*, 1984). Studies on cyclical symptoms such as early morning waking in relation to the phase changes in melatonin rhythm are being done.

Our data on a few normal volunteers show that lithium delays the secretory offset of melatonin in response to light, while it does not affect the onset of the rhythm *per se* (Nair & Hariharasubramanin, 1984). This selective effect of lithium on the suppressant effect of light, without affecting the entraining influence of light is interesting and the investigations are being continued.

We may also mention that circadian rhythm research in depression, specifically relating to an environmental Zeitgeber, will be useful to bring out the level of plasticity and adaptability of the central nervous system to the environment.

Thus, studies on circadian rhythm of human plasma melatonin in relation to photoperiod are worthy of greater attention towards identifying the basic mechanisms involved in disturbances of circadian rhythms in affective disorders.

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A SINGLE-CONSULTATION ASSESSMENT CLINIC

DEAR SIR,

I am reporting my experience of offering an urgent psychiatric assessment in the form of a single consultation, to patients and clients of any referring professional. With regard to the work of the Mental Health Advice Centre at Lewisham, (Bouras & Brough, 1982), which indicates the improvement in service when a community-based organisation is set up, it was decided to attempt to increase the range of the psychiatric service in Canterbury, without a need for an increase in resources.

As Senior Registrar in Psychiatry I was able to obtain the use of a room at the newly-built Health Centre, for two afternoons per week. Thus I was able to offer an urgent assessment (within 4 days) of patients in a non-psychiatric setting, which was the primary aim. In addition, I hoped to improve the liaison between psychiatry and other services supporting patients. Information about the clinic was circulated to general practitioners, social services, probation services, community nursing (general and psychiatric), health visitors and marriage guidance counsellors. Other referrers heard about the clinic from colleagues.

The clinic ran from June 1982 to July 1984. Records were kept for the first six months and the last year. During these 18 months 136 individuals were seen a total of 187 times, in 94 sessions. The clinics were reduced from two to one per week between the 1st and 2nd recording period, which increased the average attendance to approximately three per clinic. The greatest number of attendants at any one clinic was seven. Forty-five per cent of patients had never seen a psychiatrist before. About 50% of patients were referred by GPs. The remaining 50% were referred by: Community Psychiatric Nurses 15%, Social Workers (Community) 8%, Self or Relative 7%, General Hospital Doctor 7%, Occupational Health 6%, and Others—e.g. Samaritans, Probation—7%.

There were 97 women and 39 men, and the age range was 16–72 years. There was little difference between referrals from the different professionals. CPNs referred more psychotic patients, and self-referrals tended to be patients dissatisfied with the service that they had previously received. The diagnostic range included schizophrenia, psychotic depression and dementia, but many suffered from a neurotic illness or personality disorder; about 40% of patients had symptoms which did not readily fit a diagnosis, apparently resulting from family and marital stress or other life crises. This latter group were most helped by the single consultation and, I suspect, avoided repeated visits to psychiatric clinics. The therapeutic value of the single consultation became clear, especially its role in reassuring a non-medical professional and the patient, that the patient was not 'mad'. Approximately 40% of patients were not referred on to other services. Only 3 patients (2%) were referred for hospital admission.

My impression is that liaison between local services was improved and the service the client offered was valued by patients and professionals. One problem was that a small number of patients preferred to re-refer themselves to this clinic, rather than attend any arranged follow-up. Most re-referrals were from professionals and accounted for 51 (24%) of the consultations. The maximum number of attendances by any one individual was five. For some patients referral at approximately six-monthly intervals, at points of crisis, seemed appropriate.

I believe that this type of clinic is a valuable addition to a general psychiatric service at minimal cost, and a fuller evaluation of its acceptability and effect on other services, and comparison with other emergency clinics and crisis intervention services, would be of interest.

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KORO

DEAR SIR,

I read with interest the two brief reports on Koro (*Journal*, September 1984, **145**, 331–335). I would like to describe a case of Koro in a Chinese subject who not only had the complete syndrome, but also had an ongoing, typical schizophrenic illness. The symptoms of Koro have been present continuously and without remission for over two years.

The patient is a 23 year old single, male, Chinese was born in Hong Kong and came to England at the age of 15, with no past or family history of psychiatric illness. He completed his schooling in England by passing two "O" levels but could not achieve his ambition of three "A" levels due to deterioration in academic performance.

At the age of 21 he was admitted with a diagnosis of