impairments at the base-line interview. The sequence in which the defects are expressed in time may shed some light on the basic mechanisms that underly their co-occurrence.

For our report we have studied the cross-sectional data (base-line interview). We found that a history of a prior impairment in the affective realm singled out a group of elderly subjects. Among these subjects GMS–AGECAT depression was not associated with MMSE scores below 26. Among other elderly subjects these measurements were clearly associated, but the meaning of this relationship remains unclear.

The relationship may suggest that the MMSE impairment does, as a rule, not follow the onset of affective problems in time. Instead, the MMSE-impairment may accompany depressive disorders with a first onset in late life, occurring simultaneously. This conclusion is in line with the results of studies in which an increased rate of brain-scan abnormalities among elderly patients with a late-onset depression has been reported. The combination of late age, depression and mild impairment of MMSE-performance may indicate a specific and possibly organic syndrome that may be different from other cases of late life depression.

As Lester & Blanchard point out, 'prodromal' Alzheimer's disease is only one of the possible explanations. Functional impairment, use of medication, gender, ethnicity or anxiety may also be involved, and exploration of the roles of these variables certainly seems worthwhile.

It would be interesting to study associations of the syndrome with such variables, but also with possible symptoms of depression other than anxiety, social stress-factors and medical diagnoses. Equally interesting may be the course of the syndrome. The course may be chronic or intermittent or a dementing illness may develop. The pathological anatomical abnormalities that may be associated with the syndrome also deserve some attention. These may be similar to those found among patients with Alzheimer's disease, but one would expect the localisation of abnormalities to be different at least.

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Keeping count for the community

SIR: Wilkinson *et al* (1995) have provided a service to a catchment area with 14 stable schizophrenic patients living in it. The service consisted of one consultant psychiatrist, one senior registrar, 12 psychiatric nurses, one clinical psychologist, one senior occupational therapist, one senior social worker and two full time equivalent administrative assistants. This is in addition to primary care resources.

In the catchment area for which I am personally responsible I am aware of 180 people suffering from schizophrenia. Our team consists of myself, four-and-a-half-equivalent community psychiatric nurses, one untrained support worker and a half-time equivalent occupational therapist. Should similar resourcing be available to us there would be 12 consultant psychiatrists, 12 senior registrars, 144 psychiatric nurses, 12 clinical psychologists, 12 senior occupational therapists, 12 senior social workers and 24 full time equivalent administrative assistants. I am sure all 228 of us would do a jolly good job but how on earth would I learn all their names.

WILKINSON, G., PICCINELLI, I., FALLOON, I., *et al* (1995) An evaluation of community-based psychiatric care for people with treated long-term mental illness. *British Journal of Psychiatry*, **167**, 26–37.

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Severe apathetic hyperthyroidism with normal thyroid hormone levels

SIR: "Subclinical" hyperthyroidism (suppressed TSH secretion in the presence of normal thyroid hormone levels) is associated with an increased rate of physical and psychiatric complaints resembling those seen in overt hyperthyroidism (Scholte *et al*, 1992) and of other complications such as atrial fibrillation (Sawin *et al*, 1994). Severe apathy is well recognised as an uncommon complication of overt hyperthyroidism, but to our knowledge it has not previously been reported in a patient with normal circulating thyroid hormone levels.

Case report. A 62-year-old woman with a previous history of manic-depressive illness was admitted to hospital with a 5-month history of inactivity and progressive self-neglect. When she first became inactive the neuroleptic she was then receiving was discontinued but she deteriorated further and a presumptive diagnosis of depression was made. She did not comply with antidepressants and was admitted under the Mental Health Act in a dirty and neglected state with untreated infections of her eyes and urinary tract, and infestation with head lice. After admission she was profoundly apathetic, with

virtually no spontaneous activity, and needed prompting to attend to all aspects of her personal care. Her mood appeared flat but she denied any feelings of depression, pessimism or hopelessness, slept and ate normally, and there were no other signs suggestive of depression. Her mental state showed no improvement in the hospital environment over a 6-week period prior to treatment.

She had a previous history of hyperthyroidism and partial thyroidectomy many years earlier. Biochemical testing showed total T_4 131 nmol/l (normal range 60–170), free T_4 17 nmol/l (9–22), free T_3 8.1 pmol/l (4.6–8.2), and TSH 0.05 mu/l (0.4–5). A thyroid scintigram and ultrasound showed an active nodule in the thyroid remnant with suppression of activity in the remaining thyroid tissue. In view of the marked suppression of TSH a diagnosis of subclinical hyperthyroidism was made and she was treated with carbimazole 15 mg b.d. Steady improvement in her mental state was seen over the next 3 weeks, with increased physical activity, increased social and emotional responsiveness, and a subjective report of feeling healthier and more energetic. She proved able to care for herself once again, was discharged from hospital and has remained well since.

SAWIN, C. T., GELLER, A., WOLF, P. A., *et al* (1994) Low serum thyrotropin concentrations as a risk factor for atrial fibrillation in older persons. *New England Journal of Medicine*, **331**, 1249–1252.

SCHLOTE, B., NOWOTNY, B., SCHAAF, L., *et al* (1992) Subclinical hyperthyroidism: physical and mental state of patients. *European Archives of Psychiatry and Clinical Neuroscience*, **241**, 357–364.

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Antidepressants in pregnancy and breastfeeding

SIR: We were interested to read the letter by Kent & Laidlaw (1995) about withdrawal symptoms in a baby who had been breastfed by a mother taking sertraline.

We report a 32-year-old woman who was started on sertraline 150 mg daily when 20 weeks pregnant. She delivered a healthy baby at term and breastfed for 11 days while on the same dose. There was no behavioural change in the baby after cessation of breastfeeding. Perhaps the appearance of withdrawal symptoms is dose related in that our patient was taking sertraline 150 mg daily while Kent & Laidlaw's patient was on 200 mg.

In the absence of controlled studies on the use of most antidepressants in pregnancy and breastfeeding, it would be useful if there were a register of cases where an antidepressant had been used and of the outcome. The setting up of such a register is under consideration by the Marce Society: International Association for Psychiatric Disorders of Childbearing.

KENT, L. S. W. & LAIDLAW, J. D. D. (1995) Suspected congenital sertraline dependence (letter). *British Journal of Psychiatry*, **167**, 412–413.

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Neuropsychological function in manic-depressive psychosis

SIR: McKay *et al*'s study (1995) requires comment. It does not appear that the three groups described by the authors are entirely comparable. The impaired group had 9 out of the 10 cases with bipolar affective disorder, whereas the ratio for the younger group was 2 out of 22 and for the elderly group 1 out of 11. If comparability is assumed then an assumption also needs to be made that the underlying disease process in bipolar affective disorder and major depression is identical. This is important because impairment was predominantly a feature of the bipolar group.

If cognitive impairment is a feature of the severe and chronic state, then it is also reasonable to speculate that a spectrum of neuropsychological deficit exists that increases with increasing chronicity and severity, although no such evidence was found in this study. Incidentally neither chronicity nor severity were defined. Presumably chronicity was determined on the basis of the number of years of illness but severity is harder to understand. Was it on the basis of number of symptoms, intensity of symptoms, or the level of care required? Hopefully selection was based on identical criteria.

While the authors dismiss drug effects by citing studies that report on the effect of drugs on cognitive function while the drugs are used individually, in clinical practice that is not the case. Chronicity and severity easily translates as intractability, implying that drugs are used in combination, at more than the usual doses and for prolonged periods of