

Author's reply: Obsessive-compulsive disorder is classified as an anxiety disorder but our paper stated that our patients were free of other DSM-III-R axis I disorders. Increased brain 5-HT function may be associated with anxiety and our paper discussed this in the context of the hypothesis of Deakin *et al* (1991) that enhanced 5-HT neurotransmission may serve to restrain 'flight' and enable coping in the presence of aversive cues. There was no correlation between illness severity in our patients and prolactin response to d-fenfluramine but this, perhaps, is not surprising given the small numbers of subjects and the likely complexity of the mechanisms involved.

In some anxiety disorders, for example panic disorder, increased prolactin responses to fenfluramine can be associated with anxiety provocation during the challenge test (Targum & Marshall, 1989). However, as stated in our paper, these kind of subjective effects were not seen in our study. This makes a stress response in the patients an unlikely explanation for our findings (see Anderson *et al*, 1992).

Anderson, I. M., Ware, C. J., Da Roza Davis, J. M., et al (1992) Decreased 5-HT-mediated prolactin release in major depression. *British Journal of Psychiatry*, **160**, 372–378.

Deakin, J. F. W., Graeff, F. G., Rodgers, R. J., et al (1991) 5-HT and mechanisms of defence. *Journal of Psychopharmacology*, **5**, 305–315.

Targum, S. D. & Marshall, L. E. (1989) Fenfluramine provocation of anxiety in patients with panic disorder. *Psychiatry Research*, **28**, 295–306.

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Obsessional personality and outcome of panic disorder

Sir: The letter of O'Rourke *et al* (1997) published in response to our letter earlier this year (Tyrer *et al*, 1997) has caused us considerable distress. More particularly, the penultimate paragraph suggesting that our observation that rural Irish patients may have greater symptom stability because of anancastic personalities is "a racist joke in poor taste" is something to which we take great exception.

This possible explanation of the findings was made in the spirit of scientific enquiry and contains no element of racism. The response of O'Rourke *et al* not only

misrepresented our intentions but is also a slur on the reputation of another Irish colleague, Dr Kelleher, whose two publications on this subject were cited in our letter. In his 1972 paper (Kelleher, 1972) he showed that Irish general hospital patients chosen at random had significantly higher scores on the Leyton Obsessional Inventory than similar English equivalents, with an average score of 11 for the Irish subjects and 9.2 for the English ones. In the same paper he also showed that the rural Irish patients from the Cork area had scores which were 2.5 points higher than those who came from Cork city. In his 1982 paper (Scott *et al*, 1982) these findings were replicated, except that in addition a Scottish sample was compared and this was found to have lower obsessional scores than either the Irish or the English.

The reasons why we thought these findings may have significance in the study of O'Rourke *et al* (1996) is that in our own work we have found those who have anancastic personalities have fewer life events and show less diagnostic change than those who do not have such personalities. This is the background that led to our suggestion that rural Irish patients are more likely to have obsessional personality characteristics and that this could have clinical significance.

Kelleher, M. J. (1972) Cross-national (Anglo-Irish) differences in obsessional symptoms and traits of personality. *Psychological Medicine*, **2**, 33–41.

O'Rourke, D., Fahy, T. J., Bruphy, J., et al (1996) The Galway study of panic disorder. III: Outcome at 5 to 6 years. *British Journal of Psychiatry*, **168**, 462–469.

—, —, **Prescott, P., et al (1997)** Outcome of panic disorder (authors' reply). *British Journal of Psychiatry*, **170**, 89–90.

Scott, A., Kelleher, M. J., Smith, A., et al (1982) Regional differences in obsessional and obsessional neurosis. *Psychological Medicine*, **12**, 131–134.

Tyrer, P., Seivewright, N., Ferguson, B., et al (1997) Outcome of panic disorder (letter). *British Journal of Psychiatry*, **170**, 89.

P. Tyrer, N. Seivewright, B. Ferguson, T.

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Structural neuroimaging in learning disability

Sir: We read with interest the recent article reviewing structural neuroimaging in learning disability (Deb, 1997). For adults with

Down's syndrome a strong association with dementia of Alzheimer's type is now well established. However, the review failed to discuss the role of structural neuroimaging in the detection of Alzheimer's disease in this population. Magnetic resonance imaging has demonstrated that subjects with Down's syndrome show signs associated with Alzheimer's disease; dilatation of ventricles, increased peripheral atrophy and increased deep white matter lesions (Pelz *et al*, 1986; Emerson *et al*, 1995). For subjects with Down's syndrome with clinical dementia, atrophic changes similar to those seen in the general population of those with Alzheimer's disease are found (Kesslak *et al*, 1994; Prasher *et al*, 1996) and non-specific basal ganglia changes are seen (Aylward *et al*, 1997). We agree with the author that structural neuroimaging holds great promise for future research, especially in the assessment of neurodegenerative disorders in those with learning disability.

Aylward, E. H., Li, Q., Habbak, R., et al (1997) Basal ganglia volume in adults with Down syndrome. *Psychiatric Research: Neuroimaging Section*, **74**, 73–82.

Deb, S. (1997) Structural neuroimaging in learning disability. *British Journal of Psychiatry*, **171**, 417–419.

Emerson, J. F., Kesslak, J. P., Chen, P. C., et al (1995) Magnetic resonance imaging of the aging brain in Down syndrome. *Progress in Clinical and Biological Research*, **393**, 123–138.

Kesslak, J. P., Nagata, S. F., Lott, I., et al (1994) Magnetic resonance imaging analysis of age-related changes in the brain of individuals with Down's syndrome. *Neurology*, **44**, 1039–1045.

Pelz, D. N., Karlik, S. J., Fox, A. J., et al (1986) Magnetic resonance imaging in Down's syndrome. *Canadian Journal of Neurological Science*, **13**, 566–569.

Prasher, V. P., Barber, P. C., West, R., et al (1996) The role of magnetic resonance imaging in the diagnosis of Alzheimer's disease in adults with Down syndrome: case report. *Archives of Neurology*, **53**, 1310–1313.

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Variability in cognitive deterioration in schizophrenia

Sir: Harvey *et al* (1995) report the failure to find deterioration in the mean Mini-Mental State Examination (MMSE; Folstein *et al*, 1975) scores of geriatric in-patients with schizophrenia over one- and two-year periods. Recently, we (Laws & McKenna, 1996; Laws *et al*, 1998) have also found that people with chronic schizophrenia (as

a group) show consistent performance on cognitive tests across comparable time periods. Nevertheless, we have also documented that group consistency hides significant individual variability (this can also be seen from Fig. 1 in Harvey *et al*'s (1995) paper), and critically, that the degree of variability is related to the severity of cognitive deficits in schizophrenia.

We (Laws *et al*, 1998) examined whether famous face-naming deficits were consistent across time. While some patients showed little natural change across an 18-month period and little response to cueing, others showed significant change and high responsiveness to cueing. The former consisted entirely of chronically hospitalised patients; the latter were living in the community. Critically, variability across time correlated highly with the severity of cognitive baseline naming deficit ($r=0.84$); that is, those who were less impaired at naming faces showed greater variability across time than those with more severe face-naming deficits.

We suggest, therefore, that the data of Harvey *et al* may not address the issue of deterioration and could reflect the severity of cognitive deficit in their patients. In other words, the extremely low baseline MMSE scores (mean=13) of Harvey *et al*'s patients may make any change across time less likely. To detect deterioration, it is necessary to examine a group that is capable of showing deterioration. Finally, it is important to examine individual cases in greater detail to fully understand why some of Harvey *et al*'s patients show *improved* MMSE scores, since this has implications for those who apparently deteriorated.

Folstein, M. F., Folstein, S. E. & McHugh, P. R. (1975) 'Mini-Mental State': a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**, 189–198.

Harvey, P. D., White, L., Parrilla, M., et al (1995) The longitudinal stability of cognitive impairment in schizophrenia. Mini-Mental State scores at one- and two-year follow-ups in geriatric in-patients. *British Journal of Psychiatry*, **166**, 630–633.

Laws, K. R. & McKenna, P. J. (1997) Psychotic symptoms and cognitive deficits: what relationship? *Neurocase*, **3**, 41–49.

—, — & Kondel, T. K. (1998) On the distinction between access and store disorders in schizophrenia: a question of deficit severity? *Neuropsychology*, in press.

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Closing the gap between research and practice

Sir: I read with interest the paper by Geddes & Harrison (1997) on evidence-based medicine (EBM). They have shown that EBM is no less relevant to psychiatry than to any other medical specialty.

EBM is not simply a British (Kendell, 1997) or American initiative. Public health care in Hong Kong is managed by the Hospital Authority, a quasi-governmental body receiving a budget from the government but functioning outside the civil service itself. Annual plans on service provision are drawn up. Since a couple of years ago, we have been required to cite and rate clinical evidence according to a hierarchy very similar to that laid out in Table 1 of Geddes & Harrison's paper. After fumbling with the concept for some time, we have gradually realised the importance of EBM in underpinning our bids for resources. We cannot help echoing Geddes & Harrison's advice of adopting EBM before it is foisted upon us.

Geddes, J. R. & Harrison, P. J. (1997) Closing the gap between research and practice. *British Journal of Psychiatry*, **171**, 220–225.

Kendell, R. (1997) The College and 'clinical effectiveness'. *Psychiatric Bulletin*, **21**, 385–386.

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Doctors' dress

Sir: We read with interest the paper by Gledhill *et al* (1997) on attitudes and preferences in relation to dress and address in a sample of psychiatric in-patients. As part of a larger study (Jones *et al*, 1997) of adolescent health needs we invited healthy adolescents to respond in free text to the question "what is your ideal doctor like?". We received 451 answers, 153 adolescents specifically commenting on doctors' dress. Of these, 53% favoured casual clothes, with 47% stating that doctors should be smart or well-dressed. Only a few adolescents spontaneously mentioned that doctors should wear white coats. Several respondents mentioned personal hygiene stating that doctors should be "clean and not smelly".

When describing their ideal doctor, 60% of adolescents in our survey sponta-

neously mentioned personality, the majority saying that doctors should be friendly, easy to talk to and sympathetic. The study by Gledhill *et al* found that despite the fact that wearing jeans was associated with these qualities, they were the least favoured dress option among their sample group. Perhaps a good rapport with their doctor is a higher priority on the adolescents' agenda than on the psychiatric patients' agenda, or perhaps, as Gledhill *et al* suggest, the wearing of white coats may help to define the boundary between the internal and external worlds for psychiatric patients.

Doctors dress and terms of address is a fascinating area, with different age groups and categories of patients having different expectations. If we are going to maximise doctor-patient communication, and thereby increase patient satisfaction, we need to be aware of their expectations.

Gledhill, J. A., Warner, J. P. & King, M. (1997) Psychiatrists and their patients: views on forms of dress and address. *British Journal of Psychiatry*, **171**, 228–232.

Jones, R., Finlay, F., Simpson, N., et al (1997) How can adolescents health needs and concerns best be met? *British Journal of General Practice*, **47**, 631–634.

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Sir: We read with interest the recent paper on psychiatrists' dress (Gledhill *et al*, 1997). We undertook similar research in 1992. The purpose of our study was to assess whether the channels of non-verbal communication (attire, facial expression and posture) played a role in attributing the personality traits of competence, trustworthiness and ability to care to general practitioners.

One hundred and forty patients waiting to see their general practitioner were shown a series of photographs depicting either a sitting male or female doctor in five different dress styles, varying in formality from white coats to jeans. For each dress style there were two options for posture, relaxed or tense, and two options of facial expression, smiling and non-smiling. Subjects sorted the pictures on three dimensions: 'competence', 'trustworthy' and 'caring'.

We found that although formality of dress was important for patients in assessing competence and trustworthiness of male doctors, facial expression was more