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Correspondence

The Leicester ECT Trial: Results in Schizophrenia

DEAR SIR,

We read with interest the recent trial of Brandon *et al* regarding the benefits of ECT on schizophrenic symptomatology (*Journal*, February 1985, **146**, 177–183). Their conclusion that the improvement seen was due mainly to the beneficial effect of ECT on schizophrenic symptoms and not on affective symptoms is based on the premise that the Montgomery-Åsberg Schizophrenia Scale (MASS) is exclusively a measure of schizophrenic symptomatology. However, this is not entirely the case, for if the MASS is compared to the Montgomery-Åsberg Depression Scale (MADRS) (Montgomery and Åsberg, 1979), then three items are seen to be identical, namely 'inability to feel', 'sadness', and 'pessimistic thoughts'. One other item on the MASS can also relate to affective psychopathology, namely 'other delusions' in the possible form of 'hypochondriacal delusions'. Thus, in total one third of the twelve items of the MASS may be related to affective features and not to core schizophrenic psychopathology. We thus believe that before the authors of the paper can conclude that ECT has had a beneficial effect on the core schizophrenic features of their patients they must demonstrate an improvement, not just in the total MASS score, but in the eight items of the MASS that are free from affective bias.

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Reference

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Plasma Immunoglobulins in Depressed and Lithium-treated Patients

DEAR SIR,

DeLisi *et al* (*Journal*, December 1984, **145**, 661–666) reported that a small group of patients, principally those with a major depressive disorder, had low plasma concentrations of IgM although their IgA and IgG plasma concentrations were not significantly different from normal control values. The authors suggested that their results provided evidence for the suppression of immunity in some psychiatric patients.

In our investigation only patients diagnosed to be suffering from a major depressive disorder (Spitzer *et al*, 1978) were studied. These female patients were assessed for the severity of depression by the first 16 items of the Hamilton Rating Scale for depression (Hamilton 1967). Only patients who scored 16 or more on this scale after a 7–10 day drug-free assessment phase were included in this study. Women who volunteered to act as control subjects had no known psychiatric illness nor had taken any medication 7–10 days prior to testing. Their plasma IgA, IgG and IgM concentrations were measured using a radial immunodiffusion technique (Immuno Ltd, Sevenoaks, UK).

In order to establish the clinical significance of any changes in immunoglobulin status, euthymic lithium-treated patients were also studied.

Seventeen female patients (13 unipolar and 4 bipolar) who were being treated with long-term lithium prophylaxis for (mean ± SEM = 5.7 ± 0.6 yr) were studied. All patients, at the time of testing, were receiving lithium as their sole psychotropic medication. They had not received any other medication 7–10 days prior to testing. Their mean (± SEM) plasma lithium concentration approximately 12 hr after their evening dose was 0.89 ± 0.04 nmol/l.

No statistically significant difference was noted in the plasma concentrations of IgA and IgG between the two patient groups and the normal controls. However, the plasma levels of IgM (mean±SEM mg/dl) of the drug-free, acutely depressed patients (106 ± 14.5) and lithium-treated patients (116 ± 8.4) were significantly ($P<0.01$) lower than in the controls (176 ± 13.2). Since the controls were significantly ($P<0.05$) younger (43.1 yrs) than either the depressed patients (61.5 yrs) or the lithium-treated patients (58.5 yrs), then the lowered plasma levels of IgM may be a reflection of age rather than predisposition to affective illness. No statistically significant linear relationship could be established between age and IgM plasma concentrations in the