degree that in the six months prior to presentation she led the life of a recluse. In addition, she complained of persistent depression, hopelessness, loss of interest, loss of drive, anergia, and suicidal ideas. On examination she appeared thin and frail. Her pulse was 76 per minute and regular, blood pressure was 130/80 mm Hg. There were no tremors, eye signs, or goitre. A diagnosis of depressive illness was made and she was prescribed lofepramine. In addition to thin and frail, her pulse was 76 per minute and regular, blood pressure was 130/80.

A diagnosis of apathetic hyperthyroidism was made and she was started on carbimazole (10 mg tds).

Apathetic thyrotoxicosis occurs most often in elderly patients, and the salient characteristics that are helpful in establishing the diagnosis include typical placid apathetic facies, a small goitre, the presence of depression or lethargy, absence of ocular manifestations usually associated with hyperthyroidism, substantial muscular weakness and wasting, excessive weight loss, and cardiovascular dysfunction with atrial fibrillation (Thomas et al, 1970). Our patient showed many of these features. It is also of interest that the DST showed non-suppression. This is a confirmation of the reports by Kronfol et al (1982) and Martin & Waltz (1984), showing that DST is unaffected in depressions secondary to thyrotoxicosis.

The pathogenetic events leading to a state of apathy and depression in these patients is unknown. However, it has been postulated that there is a depletion of catecholamines or a lack of end-organ sensitivity following continual stimulation of the sympathetic nervous system.

A diagnosis of 'apathetic thyrotoxicosis' must be borne in mind when an elderly patient presents with symptoms of depression and apathy. Treatment of the endocrine dysfunction will often produce a marked improvement of the condition.

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