and what is said, in front of them, by the witnesses (including the patient) at the tribunal hearing. Anything that the patient may have said to the medical member at the preliminary medical examination is not evidence, unless it is reproduced at the hearing, and must not be taken into account.

Medical members, not having heard the views of the responsible medical officer and social worker expressed, have not necessarily formed a view of what the tribunal outcome should be before they arrive at the hearing. Moreover, there is nothing in the tribunal rules that says the medical member should discuss or even reveal what he discovered at the time of his examination of the patient, and on occasion I have refused to do so, as such discussion would clearly influence the other members' final decision.

The advantages of the preliminary examination are that it assists the medical member to ask the most appropriate questions at the hearing, and gives him or her the opportunity to peruse the clinical notes, which may contain important information not available in the reports. The disadvantage is that the preliminary examination is time-consuming, particularly if there is much travelling involved, and there are insufficient medical members of MHRTs comfortably to cover the work.

Why, 40 years ago, it was thought necessary for the medical member to make a preliminary examination is not clear, but I imagine it was primarily to allow a tribunal member to look at the hospital notes, without ruffling medical feathers. If it were possible for the notes to be made available to the whole tribunal in the half-hour before the hearing, I would have thought that we could dispense with the preliminary medical examination.

Richardson, G. & Machin, D. (2000) Doctors on tribunals. A confusion of roles. *British Journal of Psychiatry*, **176**, 110–115.

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Possible neuroleptic malignant syndrome with quetiapine

A 20-year-old man with treatment-resistant schizophrenia developed autonomic instability, hyperpyrexia and clouding of consciousness while on quetiapine. At the time he was maintained on 2.4 g sulpiride. The young man had been unwell for four years, initially in prison, the last 18 months in hospital. He suffered from a schizophrenic illness which was both severe and refractory. The situation was complicated by severe extrapyramidal side-effects with many antipsychotics and benign idiopathic neutropenia.

Sulpiride was started in March 1999, the dose in July increased to 2.4 g daily. Quetiapine was added in July 1999, to a dosage of 150 mg b.d. This was increased to 200 mg b.d. at the end of October. Compliance was assured.

In early November the patient developed a tachycardia; therefore, quetiapine was reduced to 150 mg b.d. In late November he was noted to be confused, flushed, tachycardic (130 beats per minute) and pyrexial (37.4°C). His creatine phosphokinase was 723 IU/l (range 55–120). There had been no other pharmacological interventions for 20 days.

A diagnosis of early neuroleptic malignant syndrome (NMS) was made. All antipsychotic medication was stopped and his physical symptoms resolved over 72 hours.

All antipsychotics can cause NMS (Bazire, 1999). Sulpiride was introduced in the UK in 1983. Twenty-eight cases of NMS with sulpiride have been reported to the Committee on Safety of Medicines, seven cases with sulpiride alone have been published. Quetiapine was introduced in the UK in 1997. Four cases of NMS have been reported to the Committee on Safety of Medicines, one has been published to date (Whalley *et al*, 1999).

In this case, quetiapine is the more likely causative agent as the patient had been maintained on sulpiride for many months and the onset of symptoms was preceded by a recent change of quetiapine dosage.

Bazire, S. (1999) *Psychotropic Drug Directory*, pp. 76–77, 267. Salisbury: Quay Books.

Whalley, N., Diaz, P. & Howard, J. (1999) Neuroleptic malignant syndrome associated with the use of quetiapine (abstract). *Canadian Journal of Hospital Pharmacy*, **52**, 112.

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One hundred years ago

The Medico-Psychological Association

THE next general meeting of the Medico-Psychological Association of Great Britain and Ireland has been fixed for Thursday, May 10th, and will be held under the presidency of Dr. J. B. Spence, at 11, Chandos-street, Cavendish-square, W., at 4 P.M. Much interest attaches to Dr. H. Maudsley's paper on "The New Psychology," which will take the form of critical remarks on the methods and aims of the new psychology, especially in reference to children and psycho-physical research, for not only is the subject an important one, but it is intimated that several psychologists and others interested in metaphysics will take part in the discussion. Dr. A. W. Campbell has promised to give a microscopic demonstration illustrating the arrangement of nerve fibres and nerve cells in the cerebral cortex of a series of idiots' brains, and Dr. W. J. Koenig will contribute a paper in English on "Pupillary Anomalies in Paralysed and Non-paralysed Idiot Children and their Relation to Hereditary Syphilis." On the evening of the day

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previous to the general meeting the Educational Committee will meet at 36, Queen Anne-street, while in the forenoon and early afternoon of May 10th other committee meetings will be held at Chandos-street. In the evening members will dine together at the Café Royal, Regent-street, at 7 P.M. Tickets for the dinner can be obtained (price 7s. 6d., exclusive of wine) from the honorary general secretary.

REFERENCE

Lancet, 5 May 1900, 1296.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigendum

Psychological model of post-stroke depression – author's reply, *BJP*, **176**, 295–296. Co-authors' names were omitted from the manuscript of this letter. The authors are: G. Gainotti, Institute of Neurology, Catholic University of Rome, Largo Agostino Gemelli 8, 00168 Rome, Italy; A. Azzoni, Psychiatric Service, Ospedale S. Spirito, Rome, Italy; C. Marra, Institute of Neurology, Catholic University of Rome, Rome, Italy.

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