I would suggest that macrocytosis and cognitive decline in Down’s syndrome is likely to be related to undetected folate vitamin deficiency consequent on institutional nutrition, complicated by the gastrointestinal malabsorption that some Down’s syndrome patients have.

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References


References


Admission Rates and Lithium Therapy

Sir: Dickson & Kendell (1986) recorded admissions for mania and psychotic depression in Edinburgh over the years 1970—1981 and found a rise which they could not explain. They had expected a fall, because the use of long-term lithium therapy had increased ten-fold during the same period, and they felt that their findings cast doubt on the efficacy of lithium prophylaxis in ordinary clinical practice. Such a conclusion might have far-reaching consequences for patients with recurrent manic-depressive illness, and Dickson & Kendell’s analyses merit close scrutiny.

It seems a dubious procedure to draw conclusions about the efficacy of a treatment given to a limited number of patients from admission rates for a much larger number. Not all manic-depressive patients receive prophylactic lithium treatment: it is given only to those with frequent recurrences and is started only after the patients have had several episodes. So even if lithium treatment were 100% effective, it could be expected to prevent only a fraction of the admissions for mania and depression.

Even so, a fall in the admission rate, albeit a small one, would be expected if lithium treatment was the only factor influencing admissions. It obviously was not; powerful forces with an opposite effect must have been at work. Dickson & Kendell examined some factors, such as change in diagnostic fashions or admission thresholds, but were unable to account for the rise. One could think of several others.

Be that as it may, the fact remains that the admission rate for mania and depression showed a pronounced rise, and the rise must have been caused by something. The moderate effect of lithium may...