times the corresponding average serum lithium concentrations (measured from the appropriate area under the blood concentration versus time curve). They were thus very similar to previously described concentrations of lithium in mixed saliva, which were 1.6–4.5 times those of plasma (Groth, Prellwitz, and Jähnchen, 1974).

Allowing for the very marked effects of acclimatization and for the fact that the lithium concentration of heat-stimulated sweat may differ from that of pilocarpine-stimulated sweat, we would still suggest that prolonged sweat losses of lithium should be taken into consideration, especially if a manic-depressive patient previously well controlled on lithium goes out of control in hot weather. Whether drugs which promote sweat secretion, e.g. phenothiazines, if given concomitantly with lithium therapy could lead to increased loss of lithium in sweat may be another point worth considering.

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LITHIUM AND MEMORY LOSS

DEAR SIR,

Memory loss as a complication of lithium therapy has not received extensive attention. Recently, Kusumo and Vaughan (*Journal*, November 1977, **131**, 453–7) discussed 'Effects of lithium salts on memory' and concluded that 'there was some indication that patients on lithium may show an impairment of short-term memory at fifteen-second delay intervals . . .'.

Recently G. F. Bajor and D. Preodor *et al* noted memory loss in lithium maintenance therapy, 'an inability to recall details that interfere with daily functioning'.

We have recently seen a patient with a severe affective disorder whose mood changes were well controlled with lithium but who developed a severe memory defect within a few days of starting lithium.

A 22-year-old woman was admitted in a profound psychotic depression with paranoid features. Despite management with haloperidol 20 mgm daily and imipramine 200 mgm daily, she became so profoundly suicidal that ECT was instituted in combination with imipramine. After the sixth treatment she suddenly became hypomanic. Imipramine was stopped. Four days later she was again psychotically depressed and suicidal. With one ECT she promptly became hypomanic. Lithium carbonate (900 mgm daily) was started, with consequent rapid remission of hypomania and stabilization of mood. She began to complain, however, of a severe memory disturbance. She was correctly orientated, and showed no impairment of reasoning, thought process, calculating ability or long term memory. Although she had had a typical mild retrograde amnesia after ECT, she complained that this memory impairment was different, inhibiting normal routines of life.

On close mental examination it was evident that, while both immediate and long-term recall were intact, she was unable to process new information. A delay of only a few minutes left her incapable of recalling digits, sentences, objects or daily routines.

She was so distressed that the lithium was discontinued, and there was immediate clearing of memory functions as shown by digit retention, the Babcock sentence, and recall of daily routine. Unfortunately she relapsed almost at once into psychotic depression. Because of the severity of her illness we concluded that the inconvenience of memory loss was less threatening than the suicidal-hypomanic alternations in her mood. Accordingly, lithium carbonate was cautiously re-introduced.

As her blood levels approached a therapeutic level (0 6 mEq/l) she again became anxious as her memory deteriorated. Diazepam (8 mg daily) controlled anxiety sufficiently so that despite mild memory dysfunction she was able to engage in normal social routines.

In this case memory impairment with lithium therapy was sufficiently disabling to pose a hazard to the effective management of the disorder.

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WARD ROUNDS

DEAR SIR,

Two recent accounts (1), (2), of the harrowing experience of being interviewed at a psychiatric ward round, together with Post's claim 'there is really no need nowadays to ask the patient's permission to appear at a ward conference' (3), have prompted me to respond to Dr Baxter's request for descriptions of alternatives (4).

Not having space for a general analysis of ward round functions, real and symbolic, I list only those activities which might appear to demand patients' attendance:

(a) Eliciting further details of life histories and current crises.
(b) Observation of behaviour.
(c) Listening to the patients' descriptions of their experience of their situation.
(d) The demonstration of interviewing skills (I will not consider this further, as these surely are more realistically taught to the student allowed to sit in on private interviews).
(e) Learning patients' opinions of their present treatment and wishes concerning future help.
(f) Informing patients of the treatment team's opinions and decisions.

Street is both an acute admission ward and an active member of the Association of Therapeutic Communities. A daily Community Meeting is attended by all residents and staff present, followed, of course, by a staff review. Such a regular gathering, unlike a weekly ward round, soon becomes a familiar and reasonably comfortable event for most participants, so allowing feelings of trust to develop (cf. (1) and (2)). Like a case conference, it allows all the members of the treatment team to observe identical samples of behaviour, but in a richer context of interpersonal life. To an experienced observer a Community Meeting is an extraordinarily rich source of relevant clinical information.

Once a week there is the combined ward round attended by all staff, but not by patients. The latter, however, will be familiar to most of the team through individual, group and community encounters. Activities a, b and c, therefore, do not need to take place within the ward round. The round can be devoted to consideration of psychiatric, social and other 'histories' against an existing knowledge of the patient, and to decision making.

We try to cover items (e) and (f) with two additional meetings. The first is attended by residents and some staff, one of the latter acting as 'chairman'. This meeting is used to discuss such matters as patients' opinions of treatment so far and readiness for discharge. The Chairman will record these views for the following day's ward round, and relay the team's advice back to the residents afterwards.

I am aware that our attempts to restore people's right to have a say in their own fate without '. . . adding to the discomfiture of a person who is probably distressed already' (1) are far from perfect. However, like the nurses treating 'An Ex-Patient', I would not like to be cross-examined at a ward round, and I can see no significant loss in our so sparing those who come to us for help.

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ALCOHOL WITHDRAWAL

DEAR SIR,

I would like to draw attention to some of the problems inherent in the recent hypothesis on 'Kindling as a model for alcohol withdrawal syndromes' by J. C. Ballenger and R. M. Post (*Journal*, July 1978, **133**, 1–14).

A positive correlation was shown between severity of withdrawal symptoms and duration of alcohol abuse, and the authors went on to suggest an underlying change in neuronal excitability to account for this. Their findings are only in partial agreement with evidence from other investigators, since, as they indicated, recent studies have found the severity of withdrawal symptoms to correlate with the 'seriousness' of drinking and with pre-admission drinking patterns, rather than with duration of abuse (Mello, 1972; Whitwell, 1975).

Variables, such as pre-withdrawal drinking pattern, must be carefully controlled in any study aiming to detect changes in the severity of alcohol withdrawal