hypothesis represents one of the few viable notions of aetiology and a new treatment approach. It deserves to be investigated thoroughly and with carefully designed studies in which adequate provisions are made for the heterogeneity of this condition (Singh & Kay, 1976; 1983).

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Psychiatric Disorder in the General Hospital

SIR: Mayou & Hawton (*Journal*, August 1986, **149**, 172–190) are right in asserting that there have been few systematic studies about differences in the prevalence of psychiatric disorder in the many types of in-patient and out-patient units within the general hospital. The paucity of data is most apparent in the setting of emergency departments. In a descriptive study of psychiatric emergencies in a general hospital setting, we studied 352 patients presenting psychiatric emergencies over a four-month period (1.86% of all attenders). Only 26 (7.4%) of these patients were already registered with the outpatient services of the psychiatry department, the rest being new patients. The case detection increased by 550% with the continuous presence of a psychiatrist in the emergency room—in contrast to "on-call' cover. Inaccuracies of identification were made by non-psychiatric physicians in approximately 14% of cases. Despite detection, physicians had the tendency not to refer patients to the psychiatrists-on-call. In only 34% of the patients screened, were the non-psychiatric physicians able to make a correct diagnosis of the psychiatric illness. In two-thirds of all patients, non-psychiatric physicians were unable to suggest any management for the psychiatric emergency.

Males outnumbered females in a ratio of 2:1. The majority of the patients (77%) were referred to emergency services by relatives and friends or patients themselves. Two-thirds of the patients were brought owing to the severity of the clinical condition and the rest, one-third, for medico-legal and social reasons. Approximately 80% of our patients sought consultation within one month of the onset of the illness episode. About 40% of those using psychiatric emergency services had long-standing problems of more than one year's duration. Only 10% had a history of hospitalisation for psychiatric illness in the past; and only 20% of the patients had visited emergency services more than once in the past one year. Thirty-one per cent had neurotic disorders, 26% had functional psychotic illnesses and 18% had alcohol-related problems.

There is considerable psychiatric morbidity in the emergency-rooms of general hospitals, much of which is unrecognised by non-psychiatric physicians. There is a need for improved research designs in studies of the epidemiology of psychiatric emergencies in general hospital settings, as psychiatric emergency services represent one of the chief entry points into the network of mental health services.

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Hydroxylated Metabolites of Tricyclic Antidepressant in the Elderly

SIR: We read with interest the report by Kutcher *et al* (*Journal*, June 1986, **148**, 676–679). These findings are consistent with our own experience with nortriptyline in a similar population.

Like 2-hydroxydesipramine, the 10-hydroxylated metabolite of nortriptyline is pharmacologically active (Bertilsson *et al*, 1979). In elderly depressed patients, average unconjugated plasma concentrations of 10-hydroxynortriptyline are higher than in younger patients taking equivalent doses, despite comparable concentrations of plasma nortriptyline (Young *et al*, 1984). There are also marked inter-individual differences in plasma 10-hydroxynortriptyline/nortriptyline ratio in this population. We reported development of symptoms and signs of congestive heart failure in an elderly patient with moderate plasma nortriptyline concentrations but high plasma 10-hydroxynortriptyline (Young *et al*, 1984). We also noted that, in 18 geriatric depressed in-patients, plasma 10-hydroxynortriptyline concentrations or combined plasma 10-hydroxynortriptyline and nortriptyline concentrations, but not plasma nortriptyline concentrations alone, differentiated

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