

personal management (managing, planning and control); staff management (recruitment, leadership and motivation); managing in organisation (organisational structure, culture conflict, managing change) and management and the external world. Developing the role of doctors in the management of the NHS was highlighted by the NHS Training Authority in its discussion document (1986). So management training became an ongoing process, with a number of possible options: in-service training, shadowing a manager, local mentor, managerial tailored senior registrar posts and secondment to regionally designed courses like those on offer by the North West Regional Health Authority, including the management education syllabus and open learning courses with the Open University. Therefore management syllabuses do exist. The Royal College of Psychiatrists' working party on management training (1990) stated that management training should be recognised and endorsed as an intrinsic part of psychiatric training; a management training coordinator should be appointed in all training schemes; and that the JCHPT might consider making it a mandatory requirement for approval of higher psychiatric training. So, the structure in which training and development may be delivered also exists.

A separate "core curriculum" for management training of doctors, apart from other NHS professionals, might not be the right prescription in the new NHS, where partnerships based on collaborative working and a shared sense of ownership among all interested parties are keys to success.

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Thyrotoxicosis during lithium therapy

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I read with interest the report (*Psychiatric Bulletin*, July 1992, **16**, 445–446) about thyrotoxicosis during lithium therapy in a mentally handicapped patient but do not feel it supports 'the possibility of thyrotoxicosis as a rare complication'. While the author is correct to point out that the relationship between lithium therapy and concomitant thyrotoxicosis is unclear, the case only adds to the confusion as it

contained no new data. The following points may be noteworthy.

(a) As there is no mention of pre-lithium measurement of thyroid antibody titre, thyroid ultrasonography, or even clinical assessment of thyroid status (e.g. a small firm goitre which may indicate Hashimoto's thyroiditis), it is possible that the patient suffered from (subclinical) autoimmune thyroid disease prior to lithium therapy. There is growing evidence for the immunomodulatory effect of lithium on thyroid antibody activity, exacerbation of pre-existing autoimmune thyroid disease and hence thyroid dysfunction (Wilson *et al*, 1991). Higher age group, as in this case, is a recognised risk factor for thyroid autoimmunity.

(b) The subsequent need for radioiodine for anti-thyroid treatment suggests that the patient suffered from Graves' disease (rather than Hashimoto's thyroiditis which commonly presents as hypothyroidism). Although not mentioned by the author, Graves' disease is usually associated with a diffusely enlarged, vascular, and soft-to-firm goitre. If this is the case, the thyrotoxicosis is most unlikely to be caused by lithium which has been used successfully in the treatment of Graves' disease (Lazarus *et al*, 1974). The stopping of lithium in the patients, albeit temporary, was therefore unnecessary.

(c) Data on lithium-associated thyroid disorders are overwhelmingly based on Caucasian patients living in Western countries. Recently, we studied the thyroid function of 50 Chinese psychiatric patients on chronic lithium treatment. Apart from a high rate of goitres (50%), five patients (10%) had single or multiple episodes of hyperthyroidism, whereas only two patients exhibited biochemical hypothyroidism. We argued that variation in iodine status, dietary goitrogens, immunogenetic makeup and their complex interactions with chronic lithium treatment may contribute to ethnically different patterns of thyroid abnormalities (Lee *et al*, in press). Thyrotoxicosis during lithium therapy may not be as 'unexpected' in a non-Western culture.

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