(page 129) also shows that there was one patient aged 60–65 who was trial eligible, but not a trial entrant. Table I, (pages 122–123) shows that randomisation was applied to patients only between ages 15 and 59. Why? Does this mean the researchers were reluctant to diagnose schizophrenia in a patient aged 60 or more?

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Drs Johnstone, Macmillian and Crow Reply

Sir: We limited our age range to 15–70 years largely for practical reasons. Our collaborators like ourselves generally only see patients within that range and furthermore a study which involved a 2-year follow up while the patients continued on drug regimes with stated minimum doses would have been associated with additional difficulties in the very young and the elderly. The three patients excluded from the trial on the grounds of age consisted of a 14 year old male, a 71 year old female, and a 73 year old female. The 37 patients aged 40 or over on admission consisted of 22 females and 15 males. The trial eligible patient aged between 60 and 65 who was not a trial entrant was a 65 year old lady who did not wish to participate in the trial. She would have been very welcome to do so but her refusal meant that there was no-one over the age of 60 to be included in the randomisation process.

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Alcohol Related Problems in Ethnic Minorities

Sir: We read with interest Dr King's paper on at-risk drinking among general practice attenders (*Journal*, May 1986, **148,** 533–540). We were interested to find that there were significantly more Irish and Scots among the at-risk drinkers but were surprised to note that no Asians seemed to fall into the at-risk group. This was in spite of the fact that 28% of the screened population had a country of birth outside the United Kingdom. We have recently looked at the differences in morbidity patterns between Asians and non-Asians with a diagnosis of alcoholic liver disease at the Royal Free Hospital (Banerjee *et al*, 1986). Our results showed that of the 852 biopsies performed showing alcoholic liver disease between January 1978 and November 1984, 58 (6.8%) were from Asian patients. This is a higher percentage than one would expect when corrected for the percentage of Asians in the population.

Previous studies have suggested that there are differences in alcohol sensitivity between different ethnic groups (Chan, 1986; Ewing *et al*, 1974). In addition, it has also been shown that drinking patterns vary between different ethnic groups (Caetano, 1984). We suggest, therefore, that Asians are a high-risk group for alcohol related problems (Balaharan *et al*, 1984) and the apparent low incidence of alcohol related problems in surveys may be due to socio-cultural taboos which result in under-referral to the patient's local general practitioner.

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Hypomania Following Cognitive Therapy

Sir: We enjoyed reading the letter from Drs Hughes & McKane (*Journal*, March 1986, **148,** 344). They suggest that the patient we describe is typical of a bipolar affective disorder developing in middle life. However, continued assessments of this patient for two years after involvement in the research study have shown no further episodes of affective disturbance. This might be expected in a patient with an initial diagnosis of dysthymia, which in DSM-III terms is a low grade depressive disturbance that is rarely associated with bipolar affective disorder. We were also excited by their hypothesis that the filling in of numerous questionnaires may induce mania. An examination of the data from our study reveals 120 patient-years of questionnaire administration but no other case of mania has been found. Reluctantly, therefore, we had to abandon this hypothesis. We are left, therefore, with an isolated case of mania manifested towards the end of a programme of cognitive therapy. Although no case report proves a hypothesis, it is reasonable to conclude that the