mental hospitals, let alone changing them for the benefit of their patients.

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TRAINING OF PSYCHIATRISTS

DEAR SIR,

While congratulating Dr. Russell and Professor Walton on editing the B.J.P. Special Publication (No. 5.) on the 'Training of the Psychiatrist', it is a pity that some of the cogent points in the discussion have unfortunately been left out. For instance, on page 33 (right hand top column) the purpose of mentioning that most psychiatric hospitals in this country are staffed in the junior posts by doctors from overseas, who are here only temporarily was to indicate that the training programme should at least in part be arranged to cater for the General Practitioner who initially sees the large majority of patients with psychiatric illness and who could gainfully be employed as a clinical assistant in the hospital if he were trained appropriately. However, this important climax of the point I made was left out.

Again on page 95 (bottom right hand column) the purpose of organizing the teaching programme for the part I and part II D.P.M. at the hospital was to include this in the advertisement for junior posts in the journals, and as a result to recruit the most suitable doctors since many more applied for the post than if the teaching programme did not exist. This important conclusion to the argument has also been omitted.

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MIGRAINE AND SCHIZOPHRENIA

DEAR SIR,

I have recently learned that one of my patients, a girl who suffered a severe hebephrenic breakdown (which came into full remission with very intensive physical treatment) at the age of 16, had previously suffered from what sounds to have been typical attacks of migraine, with severe headache, vomiting and prostration in early childhood, and during early adolescence she seems to have had a mild and self-limited bout of anorexia nervosa, with refusal to eat and secondary amenorrhoea. This case is of particular interest for several reasons, one being the psychopathological similarity between anorexia nervosa and schizophrenia. Another interesting point is that serotonin metabolism is thought to be involved in both migraine and schizophrenia, but attacks of migraine are rare in proven schizophrenics; this patient has not had migraine since she developed schizophrenia. One possibility that comes to mind is that migraine may act as a 'schizophrenic equivalent', and of course short-lived perceptual disturbances are quite common in migraine. Again, some people consider that migraine is related to epilepsy, and it can be quite difficult to differentiate temporal-lobe epilepsy from schizophrenia.

A further point of interest is that we found that our remitted female schizophrenics became more stable mentally and less likely to behave promiscuously when they were started on a balanced oral contraceptive, such as Ovulen. I have found that migraine also tends to remit on balanced oral contraceptives, the remaining attacks tending to occur at the end of the withdrawal period,—often the day when the next course is due to start, i.e. when the serum hormone concentration is at its lowest.

These purely clinical observations suggest some fascinating possibilities for further biochemical research, and I wonder if any of your readers can throw any light on them, or know of similar cases of their own.

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Inverness.

ERRATUM

CONCURRENCE OF TURNER'S SYNDROME AND ANOREXIA NERVOSA

It is regretted that the name of Dr. F. M. M. Mai of the University of Rochester School of Medicine and Dentistry, 260 Crittenden Boulevard, Rochester 20, New York, was omitted as a co-signatory of the letter published under the above heading on page 237 of the *Journal,* August 1970.