

The first Royal College

Sir: I had the opportunity to see a book by Julius (1844) about his two visits to British asylums in 1834 and 1841. In both years he visited Hanwell and Conolly. The book tells us that it was written during the journey, but published later. Julius recounts the founding of an English association of psychiatrists and complains about the fact that in Germany such a society did not yet exist in spite of several attempts to found one. This, I think, makes it clear that what is now the Royal College in fact was the first in the world; the German association came second, founded in 1842.

The book is in itself interesting enough about early English-German relations in psychiatry. It contains also a German translation of the long foreword, which had been written by Samuel Tuke for the English translation of Maximilian Jacobi's (1834) book on the management of psychiatric institutions. The translation had been made at the instance of Tuke.

JACOBI, K. W. M. (1834) *Ueber die Anlegung und Einrichtung von Irren-Heilanstalten mit ausführlicher Darstellung der Irren-Heilanstalt zu Siegburg*. Berlin: G. Reimers. (English translation ed. by Samuel Tuke (1841) *On the Construction and Management of Hospitals for the Insane*.)

JULIUS, N. H. (1841) *Beiträge zur britischen Irrenheilkunde, aus eigenen Anschauungen im Jahre 1841*. Berlin: Enslin.

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Longitudinal screening of thyroid dysfunction in adults with Down's syndrome

Sir: A clinical, pathological and immunological association between thyroid dysfunction (TD) and Down's syndrome (DS) is well established (Pueschel *et al*, 1991). TD is a heterogenous disorder, with definite hypothyroidism and subclinical hypothyroidism being the two commonest abnormalities. There is, however, an absence of information regarding longitudinal findings of TD in people with DS.

Of 201 adults with DS recently screened for TD (Prasher, 1994) thyroid status results were available for 52 subjects for three consecutive years. Six subjects were excluded as they were being treated with thyroxine replacement during the study period. Mean age for the remaining 46 subjects at the start was 44.85 years (s.d.=13.68; range 19-71 years). Twenty-eight (61%) were male and 18 (39%) female.

Findings confirmed the high prevalence of TD in adults with DS; 48.1% at initial testing. Most

individuals who were euthyroid at the start remained so two years later (85%). Four subjects developed abnormalities within the following two years (incidence rate per year 7.4%). Eight (17%) subjects had subclinical hypothyroidism on initial testing of which three (38%) reverted back to being euthyroid two years later. Only one subject with subclinical hypothyroidism at the start of the study went on to develop definite hypothyroidism at the two-year follow-up. The incidence rate for subclinical subjects to develop definite hypothyroidism was 6% per year. Fluctuations in mean free T4 and thyroid stimulating hormone (TSH) levels for the group as a whole occurred over the two-year study period (Friedman two-way ANOVA=8.4 and 10.1 respectively; $P=0.01$).

Thyroid dysfunction in adults with DS is a heterogenous disorder consisting of transient and persistent abnormalities. A significant number of adults with normal thyroid status will develop TD during the following two years (incidence rate of 15%) but few will develop definite hypothyroidism. Further, plasma levels of free T4 and TSH can fluctuate significantly over a short period. Longitudinal data is important to understand the natural history of TD in people with DS. It will enable doctors to determine how often testing of thyroid status should be undertaken in individuals for whom venesection can be difficult, and to determine whether borderline and/or transient changes require treatment. Further areas of research investigating prognostic value of antibody determinations along with cost-benefit aspects of thyroid screening are recommended.

PRASHER, V. P. (1994) Prevalence of thyroid dysfunction and autoimmunity in adults with Down's syndrome. *Down's Syndrome Research and Practice*, **2**, 67-70.

PUESCHEL, S. M. & PEZZULLO, J. C. (1985) Thyroid dysfunction in Down's syndrome. *American Journal of Diseases of Children*, **139**, 636-639.

—, JACKSON, I., GIESSWEIN, P., *et al* (1991) Thyroid dysfunction in Down's syndrome. *Research in Developmental Disabilities*, **12**, 287-296.

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The time span of the mental state examination

Sir: The mental state examination (MSE) is the most important and often the only objective part of the psychiatric assessment. The MSE is the equivalent of the physical examination in the rest of medicine and is considered to be a cross sectional examination. There seems to be disagreement among experts as to the time span covered in the MSE. For some, it describes what is happening at that moment. For example, while assessing mood, they stick to the subjective and

objective mood and the associated behavioural manifestations. Others extend the time span to cover a period of up to 24 hours and also comment on the diurnal variation of mood. Some go further to include disturbances of sleep and appetite and even changes in body weight, the latter usually not occurring over a few days. This leads to a blurring of the boundary between the history of the illness and the MSE and raises the question as to how much of the history should come into the MSE. This discrepancy may not be dangerous in routine patient care, but it does cause considerable anxiety and confusion in the candidate sitting the MRCPsych clinical examination. We would like to hear the opinion of the College in this regard.

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Sir: The method employed in the examination of the mental state is clearly dependent upon psychiatric training and orientation. I believe that your correspondents realise that their query is likely to provoke a variety of replies. However, I do have views on the matter, although I would not claim that these should prevail on the MRCPsych examinations and they certainly do not constitute the official opinion of the College.

If the MSE is the precise analogue of the physical examination it would apply on to the findings at the time of the examination. This would often be unsatisfactory as many psychiatric symptoms are not continuously present even in patients seriously unwell. As your correspondents say, it is common practice to ask patients about their symptoms in the previous 24 hours. Diurnal variation in psychopathology is an important aspect of the mental state and clearly requires enquiry about symptoms during a 24-hour period. I would not regard enquiry about bodily functions as falling into the examination of the mental state, but into the 'history of the present complaint'. However, one must not be too dogmatic or rigid, for example, it is relevant to enquire of the patients' frame of mind when they are lying awake following early wakening. In this context it is worth remembering that the way in which information is collected should be acceptable to the patient; the way information is ordered and considered, and the way it is presented to others is a matter for the psychiatrist.

Your correspondents refer to "the subjective and objective mood and the associated behavioural manifestations". I find this confusing as

'behavioural manifestations' are to me the 'objective' manifestations of mood. Mood itself I regard as entirely subjective; the task of the psychiatrist is to enable the patient to describe what may be unfamiliar and perplexing emotions in words with which they are familiar.

Examinees should develop a sound technique for the examination of the mental state and be prepared to defend their approach to the examiners.

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Psychiatry in Russia – anyone interested?

Sir: I am pleased that the need for increased international links with Russian psychiatry was recently highlighted (*Psychiatric Bulletin*, November 1995, 19, 703). It is very important that the effects of past isolation and current economic problems on Russian psychiatry are overcome as soon as possible. For the last four years I have been closely involved with a small group of other interested British psychiatrists in developing professional links between the two countries in the field of forensic psychiatry (Gordon & Meux, 1994) and, to a lesser extent, in other psychiatric subspecialties and branches of medicine. Just as British psychiatry was involved in strongly commenting upon past unacceptable practices in Soviet psychiatry we must now be in the vanguard of influencing positive change. I am currently the Project Leader of a British Council funded project to further develop links. A series of exchange visits have occurred involving over twenty personnel from various regions of Britain and Russia including numerous institutions ranging from hospitals of different levels of security to research institutes, medical schools and prisons. Vital provision of information and sharing of experience during these visits has occurred and facilitated attendance at relevant Conferences in each other's countries, publications in each other's journals (e.g. Kachaeva, 1995), exchange of books and journals and the commencement of research collaboration. A psychiatrist from Moscow last year completed the international Diploma in Forensic Psychiatry course organised by the Institute of Psychiatry and other disciplines have also been involved.

Current collaboration is occurring in the areas of training and education, clinical practice, service provision and research. I hope that, subject to continuing financial sponsorship, the links can continue to develop. The mutual trust that now exists smooths the bureaucracy involved and I have frequently been the first