Health, an administrative officer, and mental welfare officers of the local health department. The hospital representatives are the Consultant Psychiatrists, the hospital's Director of Rehabilitation, Psychiatric Social Worker and Senior Ward Nurses.

The meeting serves a number of purposes. Firstly, they bring together members of the local authority and hospital staffs to form a team to discuss patients' progress and placement. Secondly patients who are ready for accommodation outside hospital are brought to the notice of the local authority. Thirdly, there is the opportunity to consider the priorities of patients who may be awaiting admission. Fourthly, the need to renew and reinforce communications between home and patient is often revealed.

Unfortunately, not all the excellent recommendations in the Royal Medico-Psychological Association's Memorandum are likely to be implemented in the near future; but the mental health liaison committee provides one means of overcoming some of the inadequacies and differences which arise in the present arrangement for the care of the mentally handicapped.

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MIGRAINE, ANOREXIA NERVOSA AND SCHIZOPHRENIA

DEAR SIR,

Whilst I appreciate Dr. Gosling's interesting points (*Journal*, November, 1970), some doubt has been expressed about the use of oral contraceptives in migrainous subjects in view of the preliminary stage of cerebral arterial constriction, at which time it was thought that thrombus formation might be encouraged. No doubt this risk is less since the 'Scowen Scare', but should still be borne in mind.

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UNIPOLAR AND BIPOLAR AFFECTIVE PSYCHOSIS. THE PROBLEM OF CLASSIFICATION ILLUSTRATED BY A CASE HISTORY

DEAR SIR,

Leonhard (1) suggested that on purely clinical grounds affective psychosis could be classed as unipolar (attacks of depression only) or bipolar (attacks of depression and mania). Perris (2) compared the expectation of bipolar and unipolar psychosis in the relatives of a series of 138 patients with bipolar psychosis (patients who had had at least one attack of depression and one of mania) and 139 patients with unipolar psychosis (patients who had had three discrete attacks of depression), and produced evidence that these two classes might be genetically distinct. A difficulty with such studies is that until the patient's death there is no certain way of classifying his psychosis. Perris (3) later showed that attacks of mania were very uncommon after more than four depressive attacks. However, the present case history shows that typical mania may occur after as many as 13 distinct depressive attacks.

Case History

The patient was born in 1907. She was the second in a family of six and has had three daughters. There is no family history of mental illness. She married in 1935, and her husband, a boilerman, died in 1955. For many years she has worked as a laundry presser. She is described by her daughter as being energetic when well, but of a suspicious nature.

Her first depressive illness occurred in 1933 at the age of 26. This lasted a month, and a year later she had another lasting about the same period and requiring hospital admission. She had no further mental illness for over 20 years, but between the ages of 49 and 59 she had eleven hospital admissions for depression. These recurrences tended to develop acutely (in a week or two) and to be characterized by retardation, ideas of unworthiness, insomnia, anorexia, and (in the early attacks only) hostility towards her family. On five occasions she attempted suicide. Bouts of drenching perspiration heralded the onset of each attack, but no significant abnormality in her physical health has been found to account for this. The attacks each lasted 2 to 4 months and were variously treated with drugs and ECT. In between her psychotic episodes she kept at work and lived a normal active life.

At the age of 59, she had her twelfth hospital admission for depression, but after 26 days (and on antidepressant drugs) she became manic, elated, overactive and overtalkative and making amorous advances to male patients. This was an astonishing change in a patient so well known to the hospital staff. After two months she recovered her normal health. During the next 18 months she had two more attacks of depression, but during her fifteenth admission (age 61), again for depression, she had a further manic episode. Since then she has had two further admissions for depression only.

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