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### Multifactorial intoxication?

SIR: I read with interest the article by Peh *et al* (*Journal*, June 1990, **156**, 891–893). However I fear that the discussion of possible mechanisms is perfunctory and potentially misleading.

Hyponatraemia is a relatively common finding in clinical practice, and numerous possible causes have been recognised (Foote, 1990). Spurious analytical errors may occur either from 'drip artefacts' or from conditions of hypertriglyceridaemia or hyperproteinaemia. Convincing evidence against these potential errors is lacking in the case described.

The limited clinical data given indicate the presence of a cardiomyopathy in a relatively young woman, apparent from early 1984, and the injudicious use of small quantities of intravenous fluid is dangerous, with disastrous consequences in this case. Biochemically, a picture of hypervolaemic hyponatraemia would be expected.

The syndrome of inappropriate antidiuretic hormone (SIADH) is rightly discussed, albeit briefly, by the authors. However no mention is made of tolbutamide's recognised ability as a sulphonylurea to induce this endocrinological abnormality. Moreover, head injury, convulsions and 'psychosis' are all described as individual causes of the same syndrome of excess antidiuretic hormone secretion in the face of low serum osmolality.

I would propose that the reasons for this unfortunate woman's hyponatraemia are at least multifactorial rather than isolated water intoxication as suggested.

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### Memories in depression: pleasant or unpleasant?

SIR: It is generally accepted that depression is associated with unpleasant memories which are congruent with the affective state (e.g. Dunbar & Lishman,

1984; Teasdale & Dent, 1987). However, we have repeatedly been finding contradictory results regarding memory while studying other phenomena in pre-electroconvulsive therapy (ECT), drug-free, depressed (DSM-III-R diagnosed) patients admitted to hospital. For example, we unexpectedly found that over a period of 72 hours, depressives forgot significantly ( $F=6.283$ , d.f. 1,20:  $P<0.021$ ) more negative than positive affect words, as compared with normals and schizophrenics (e.g. Calev, 1988).

In another study (Bachar *et al*, 1987), pre-ECT depressed patients tended to produce, during a reminiscing interview (encouraging subjects to speak about events which happened five years or more previously), more positive memories (mean = 51%; s.d. = 37) than did normal controls (mean = 44; s.d. = 15), although this difference was not significant. In a reminiscing group (Bachar, submitted), depressed patients produced a mean of 83% (s.d. = 18) positive affect memories. In a study of dream recall (Bachar, in preparation), we found that depressives tended to recall more positive than negative dream contents. Twenty-one out of 37 dreams were classified as positive (using Hole & Castle's (1966) classification system), and only 16 dreams were classified as negative. While dream recall norms are lacking, this finding once again shows that depressives tend to recall more positive than negative contents.

The common denominator of all our findings, in contrast to most former findings, is *delayed testing* for the 'to-be-remembered' materials. It is thus possible that positive emotional contents may be suppressed and temporarily unretrievable during depression because of state-dependent negative thought-processes. These negative materials may be well consolidated in memory, as shown by our paradigms (delayed recall, remote memory reminiscing, and dream recall). Depressives may retrieve these memories later and use them as a means for recovery.

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