There has thus been support for this finding and for providing this simpler form of surgery, which can be done at a regional level (Snaith, 1989).

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SIR: In their recent paper, Lovett *et al* (*Journal*, October 1989, **155**, 547–550) repeat the advice from a previous paper (Lovett & Shaw, 1987) that stereotactic tractotomy may give a poorer outcome in patients with organic cerebral changes. They again quote a bipolar case (no. 4) from their 1987 series as showing a particularly poor course after, and possibly before, the woman's second operation in 1981. This was associated with embolic cerebral damage.

Unknown to the authors, this woman, two-and-a-half years after her second operation, showed an almost complete resolution of affective symptoms that allowed her eventually to be transferred from long-stay to out-patient care. For the last five-and-a-half years she has suffered from neither mania nor depression, and her only psychotropics are diazepam (5 mg) in the morning and temazepam (20 mg) at night. If anything, her organic cerebral changes came on after the extension operation, since a preoperative Emergency Medical Information scan was reported as normal. Since that time she has experienced several cerebral infarctions in both frontal areas from emboli due to mitral valve disease, but has recovered well from the resulting brief hemiplegia and dysphasia.

She walks normally, although her speech can become muddled when she is under pressure, and very occasionally she is a little 'high' and 'interfering' for some hours at a time.

I have no doubt that this woman would never have been discharged nor have been free of affective illness without tractotomy. The recovery two-and-a-half years after the operation may seem late, but it may possibly have been delayed by the stroke eighteen months after operation, or alternatively the stroke may have represented a further and curative extension of the limited surgery to her frontal tracts.

Certainly, it would seem too early to regard cerebral changes as an absolute contraindication to psychosurgery.

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## Forensic aspects of mental handicap

SIR: Turk's annotation on the forensic aspects of mental handicap (*Journal*, November 1989, **155**, 591–594) is timely in bringing this issue to prominence. However, I feel that he omits to mention an important cause of distortion in the available figures relating to mental handicap and criminal offences, namely the great reluctance of the police to prosecute people with a mental handicap. As a result, the available figures on any relationship which may exist between crime and mental handicap are not a true reflection of the situation. For example, over the last six months I have seen six individuals each of whom have committed what would normally be regarded as criminal offences, including assault, theft, destruction of property, sexual offences, and various minor nuisance offences. None of these people were prosecuted by the police although they were, in three cases, brought into our hospital by the police. It is of course debatable how far prosecuting an individual with a mental handicap serves any useful purpose, and this is not a plea for the wholesale prosecution and imprisonment of all mentally handicapped offenders. However, until we can collect more accurate figures about offences committed by people with mental handicap, it is misleading to use existing figures on convicted persons as an indication of the presence or absence of relationships between intellectual retardation and criminal behaviour.

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## Asian patients and the HAD scale

SIR: I was puzzled by the letter from Chaturvedi (*Journal*, January 1990, **156**, 133) as it appears he has failed to grasp the content of my article (*Journal*,