116 mmol/l, urea 2.1 mmol/l, serum osmolality 242 mOsm/kg; the plasma ADH level was not determined. Water restriction resulted in clinical and biological improvement.

In the first two cases, the results were consistent with water intoxication secondary to psychogenic polydipsia, with a resetting of the ADH osmostat (Caron *et al*, 1977; Robertson, 1980; Singh *et al*, 1985); the plasma ADH level was inappropriately high for the plasma osmolality. In the third case, the finding of concentrated urine suggested the classic form of SIADH. Our three cases confirm that there are two distinct forms of SIADH—the classical and an atypical one. It can occur in different mental illnesses, with or without the use of neuroleptics. Measuring the plasma ADH level on admission and during a water-loading test ten days later can distinguish between an inappropriate secretion of ADH with a resetting of the osmostat, or a mild form of SIADH (Rosenbaum *et al*, 1979). Our third case, of a patient with tardive dyskinesia and polydipsia, may confirm the hypothesis of hyperdopaminergic activity (Smith & Clark, 1980).

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Lithium in Severe Depression

DEAR SIR,

Lithium in combination with tryptophan and a monoamine oxidase inhibitor may be useful in the treatment of chronic or resistant depression (Barker & Eccleston, 1984). Lithium has also been shown to have acute antidepressant activity comparable to imipramine (Worrall *et al*, 1979). We have recently seen a case of recurrent unipolar depressive illness of psychotic intensity which would appear to respond only to lithium but not to ECT or to combinations of antidepressant drugs.

The patient, a 60-year-old man of good work record, no family psychiatric history and no evidence of physical illness or intellectual impairment had an episode of depression seven years ago which responded to a course of ECT. Three years ago he became depressed again with biological depressive symptoms and delusions of guilt and unworthiness. There was no response to six months' treatment which included two courses of ECT, adequate trials of amitriptyline, dothiepin, mianserin and nomifensine, and of phenelzine used singly and in combination with amitriptyline. Eventually lithium alone was tried and he made a rapid and complete recovery after two weeks.

On follow-up his recovery was maintained but later the lithium was discontinued at his own request due to weight gain. He relapsed and was readmitted. Lithium was withheld due to the patient's reluctance. He remained unresponsive for a year to ECT, various tricyclics used singly and in combination with a monoamine oxidase inhibitor (in this instance tranylcypromine) as well as sleep deprivation. Finally lithium was again tried (to achieve a serum level of around 0.7 mmol/l at 12 h post-dose) and he showed a rapid and complete response which began after about two weeks.

It has been suggested (Abou-Saleh & Coppen, 1983) that the *prophylactic* effect of lithium is more marked in patients with high Newcastle scores (i.e psychotic depressives). If this applies also to the *acute* antidepressant effect, as this case suggests, then perhaps a trial of lithium is a reasonable alternative to ECT in certain severely depressed patients who are either unresponsive or unsuitable for electrical treatment or other antidepressant drugs.

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Suicidal Behaviour and Child Abuse

DEAR SIR,

Having read with interest the paper on the risk of child abuse among mothers who attempt suicide by