the literature, there is no mention of exacerbation by anticholinergic agents.

The phenomenon of "delayed-onset dystonia" has been reported by Burke *et al* (1980): eight cases of persistent dystonia appeared years after non-progressive cerebral insults, including perinatal anoxia, trauma, and cerebral infarction. There was no history of neuroleptic treatment. It is interesting to note that the patient reported by Cooper *et al* had a history of prematurity, two perinatal anoxic episodes, epilepsy, and a focus of left temporal spike waves on the EEG.

The brain damage may have acted as a predisposing factor for the development of tardive dystonia in this patient. Another possibility is the occurrence of delayed-onset dystonia in a patient on neuroleptic treatment. One of the diagnostic criteria for tardive dystonia is exclusion of secondary causes of dystonia (Burke *et al*, 1982). Delayed-onset dystonia is one which may easily have been overlooked.

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## Nicotine and dementia

SIR: The results reported by Sahakian *et al* (*Journal*, June 1989, **154**, 797–800) on the effects of nicotine in patients with dementia of the Alzheimer type are interesting and clearly warrant further evaluation. We would however like to raise some methodological concerns.

Firstly, the inclusion of cigarette smokers is questionable. There is evidence that prolonged or repeated exposure to nicotine can cause a desensitisation blockade of the receptors (Wonnacott, 1987) and that, as a result, subjects who smoke regularly may be less sensitive to the effects of subcutaneous nicotine. In addition, the density of nicotinic receptors in the brain has been shown to be increased in brain tissue taken from habitual smokers (Benwell *et al*, 1988). Although the possible psychopharmacological consequences of the change in receptor density remains to be established, it seems reasonable to suggest that patients who are also regular smokers may not respond to systemic nicotine in the same way or to the same degree as non-smokers. Therefore, the apparent lack of response to the drug in some of the tests (e.g. the short-term memory test) may simply reflect the heterogeneity of the patient population used.

Secondly, there is wide intrasubject variability in performance on cognitive tests in demented patients. Since the effects of subcutaneous nicotine are of rapid onset it is feasible to test the patients before and after administration of drug or placebo at each session. Positive results with this experimental design would be of greater significance.

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## Depression-dependent exacerbation of TD

SIR: I read with interest the case "Depression-dependent exacerbation of tardive dyskinesia" reported by Sachdev (*Journal*, August 1989, **155**, 253–255). The case is presented well, but I would like to draw readers' attention to previous literature on this topic.

Yassa *et al* (1983), investigating patients with affective disorder, found a prevalence of tardive dyskinesia (TD) of 41%, with affected patients being older than those without TD. Yassa *et al* (1987) went on to investigate patients being started on antidepressants. Of 50 patients, three developed TD, two improving on withdrawal of the drugs. They quote a number of authors who have reported both the presence of TD in patients on antidepressants (15 cases) and others describing affective disorder as an exacerbating risk factor for TD in other disorders.

I would support Sachdev in the assertion that current biochemical theories are contradicted by these cases and that new explanations will have to be found. I would add that the model would have to take account of possible predisposing factors (age, sex, previous neuroleptic use, organic damage,

alcohol use) as well as concurrent medication and mental state.

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## Physical morbidity of psychiatric patients

SIR: I was a little troubled by the study of Honig *et al* (*Journal*, July 1989, **155**, 58–64) looking at the physical morbidity of psychiatric patients. A recent and well conducted study by Ziber *et al* (1989) suggests that, considering all classes of psychiatric patients, the standardised mortality ratio was 2.3. The major causes of death were related to dysfunction of the cardiovascular and respiratory systems, probably because of excessive smoking. Another recent study, by Casadebaig & Quemeda (1989), on mortality among psychiatric in-patients, also commented upon an excess of deaths through cardiovascular and respiratory disease.

The age of patients in the study by Honig *et al* was only 45 years, and hence slightly below the age of major risk for such complications. It is however very narrow-sighted of them not to comment upon the likely illnesses which face the slightly older group of psychiatric patients and not to emphasise the important health education role of the psychiatrist.

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## Benzodiazepines unabashed

SIR: It was refreshing to read Kräupl Taylor's article on benzodiazepines (*Journal*, May 1989, **154**, 697–704), following the bashing this particular group of drugs has been subjected to recently. I have used various benzodiazepines to treat anxiety states in the past few years and find them extremely useful. As with any other drugs there should be indications to use them and they can be abused by way of over-prescribing both by doctors and by the public. Whatever the research workers might say, in my opinion, there is a minority of patients who seem to benefit from them even on long-term therapy (more so on a *pro re nata* basis), and I do not think this is due to psychological dependence alone.

I was most surprised to hear about the recent proclamation issued by the Royal College of Psychiatrists pertaining to the duration of benzodiazepine therapy. I think this is an insult to the clinical judgement of doctors, and furthermore could cause confusion among the public. We all can have strong opinions about various aspects of drug therapy, but we should not necessarily impose these on others. (I am reminded of a clinical director who sent out a circular to all the staff members and residents prohibiting the use of intramuscular diazepam, and of another instance where a decision was made to ban the use of triazolam in a leading psychiatric department in Canada.)

In the light of these developments it is also interesting to note the course taken by some of the leading research workers. In the initial phase they bring out numerous research papers describing the virtues of the drug, in the middle phase they are busy publishing papers on the side-effects of the drugs, and lastly they bombard us with research work pertaining to the withdrawal effects of the drugs, and go a step further in condemning some doctors for being over-zealous in prescribing these drugs. Most of us are aware of this scenario and tend to take all kinds of psychiatric research and especially 'new and dramatic developments in psychiatric research' with a pinch of salt.

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## Remission of psychotic symptoms after burn injury

SIR: Self-incineration is a rare but dramatic way to attempt suicide. Its symbolism as a form of political protest (Crosby *et al*, 1977), or religious phenomenon (Topp, 1973), its relationship to underlying psychiatric disorders (Jacobson *et al*, 1986),