two years, and Brincat *et al* (1984) have shown a recurrence of depression and other related symptoms when patients well controlled with implants for many years are then given a placebo. The same percutaneous implantation of 100 mg oestradiol every six months was used to treat depression in younger women with pre-menstrual syndrome and was found to be more effective than placebo in every Moos cluster of symptoms including negative affect (Magos *et al*, 1986). This is not transient as a sustained improvement has been reported after five years of such therapy (Watson *et al*, 1990).

Oestradiol implants have a prolonged duration of action which may be undesirable in some patients. Transcutaneous oestradiol patches in high doses (Estraderm, 200 μg) which do not have this long-term characteristic have also been studied with equally impressive effects on depression when compared with placebo (Watson *et al*, 1989).

These findings are not unique to our clinic but the space and number of references permitted in this letter do not allow me to give details of data from Montreal, Cardiff and London which support this view.

All doctors who treat depressed peri-menopausal women, regardless of the finer definitions of depression, should be aware of the potential that oestrogens have in relieving the suffering of some (or many) of these women. Nobody makes any claims that oestrogen therapy is a panacea for all the psychiatric problems of middle age, but patients deserve that the place of this therapy is evaluated carefully and not dismissed in such an unscholarly review.

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AUTHOR'S REPLY: Dr Studd and his colleagues express some dissatisfaction about the choice of references in my review, but I can only reiterate that the majority of general population studies do not support the view that the menopause or climacteric is associated with a significantly increased risk of psychiatric disturbance in women. In addition, the majority of treatment studies do not support the view that oestrogen has a specific antidepressant effect, but many women feel better if their symptoms of flushing and sweating are effectively relieved and this complicates the interpretation of many studies.

The 'ovarian cycle syndrome' described by Dr Studd and his colleagues and said to be common is difficult to evaluate in that the physical symptoms described may well make a woman feel depressed and, conversely, a depressed woman may be much less tolerant of, and more disturbed by, these cyclical changes in sensation. Symptoms such as loss of energy and loss of libido are certainly very common in straightforward depressive illness.

Several studies have shown that women attending gynaecology out-patient clinics have higher levels of psychiatric morbidity than matched controls from the general population (Munro, 1969; Worsley *et al*, 1977; Byrne, 1984). Dr Studd and his colleagues will see many depressed women who benefit from their clinic attendance. However, I would question the view that oestrogen implants are the main therapeutic agents as far as psychiatric symptoms are concerned and would suggest that it is the very obvious concern and enthusiasm of the staff that is of prime importance, as suggested in the study of Strickler *et al* (1977).

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The 'new cross-cultural psychiatry'

SIR: Littlewood (*Journal*, November 1990, **157**, 775–776) has misidentified a 'conventional error' in my editorial. I did not suggest that culture should be held