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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Skull radiology in patients with psychiatric illness

SIR,—It seems that even psychiatrists are playing "the numbers game" now. I refer to Dr Sudhir C Rastogi and Dr Brian M Barraclough (29 October, p 1259), who argue against routine *x* ray procedures in patients with psychiatric illness. Retrospective analysis of the yield from investigations of this sort has greatly advanced the management of head injury (22 October, p 1173), but it is questionable whether psychiatry is as reducible. I make these comments in the light of my experience of two patients investigated recently at this institute. Both presented with dementia and personality change in the presenile age group, and both were found to have meningiomas accounting for their mental state. I wish to draw attention to these cases because the meningioma, unlike many neurological conditions, is the treatable cause of psychiatric disturbance par excellence. Each patient had obvious abnormalities on plain skull *x* ray films and could have been diagnosed definitively by standard isotope brain scanning. Unfortunately, the diagnosis was not suspected until the tumours were very large, creating technical difficulties for the neurosurgeon.

Meningiomas are more common in psychiatric inpatients than in hospital controls[1] and presumably contribute to their illness.[2] A high index of suspicion is required if these lesions are to be identified, so clinicians should not be inhibited by an apparently low return on some simple tests. If the purpose of the aforementioned paper is to tell us that "blanket" radiology is no substitute for clinical skill then it succeeds in its limited aim. Statistical audit of investigations should, however, be regarded as an adjunct to patient management and not a substitute.

Only gamblers rely on "the numbers game," and their lack of success is proverbial.

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[1] Patton RB, Sheppard JA. Intracranial tumours found at autopsy in mental patients. *Am J Psychiatry* 1956;**113**:319.
[2] Avery TL. Seven cases of frontal tumour with psychiatric presentation. *Br J Psychiatry* 1971;**119**:19-23.

SIR,—We should like to support the findings of Dr Sudhir C Rastogi and Dr Brian M Barraclough (29 October, p 1259) that routine skull radiography is of little value in patients with psychiatric illness.

As part of a wider prospective survey we have performed skull radiographs on 57 patients referred from a psychiatric hospital with a variety of diagnoses. Findings of all of these examinations were normal. We conclude, therefore, that skull radiography is of little value in patients with psychiatric illness where there is no specific physical abnormality.

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SIR,—Dr Sudhir C Rastogi and Dr Brian M Barraclough (29 October, p 1259) assert that computed tomography, along with other more routine radiological procedures, has little to offer in the diagnosis and management of psychiatric illness. Their small heterogeneous sample may have misled them in this respect. Computed tomography remains a new technique, and research into its proper place in psychiatry is far from completed. Dr Rastogi and Dr Barraclough argue against its use as a