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),

and psychoanalytic accounts of its significance (Friedman *et al*, 1972), have all been examined, but very little has been written about the effect of deliberate or accidental burning upon the mental state of the psychiatric patient. We report two cases where psychotic symptoms appear to remit after significant burn injury.

Case Report A: A 31-year-old Afro-Caribbean man was admitted urgently after being found wandering in a mute and inaccessible state. He had been first admitted ten years previously, when hebephrenic schizophrenia was diagnosed, and there had been two subsequent admissions, each characterised by flattened, occasionally fatuous affect, auditory hallucinations, and paranoid delusions. His one full sibling was similarly afflicted, but neither parent and none of six half-siblings had any psychiatric history. His response to treatment with oral and depot antipsychotics had previously been slow, but eventually complete, although he had been lost to follow-up for five years. Informants gave a history of six months of increasingly bizarre behaviour, and when he began speaking a few days later, mental state examination revealed auditory hallucinations and paranoid delusions. Two weeks after admission he sustained 5% mixed thickness burns to his torso after accidentally igniting his bedding while smoking. After initial analgesia and dressing he was transferred to a regional burns unit for skin grafting. He remained free of psychotic symptoms throughout his one-month stay there, and for a further two weeks after his return to the ward, when the earlier symptoms re-emerged, associated with some manic features, and required in-patient treatment for a further six months.

Case Report B: A 67-year-old Caucasian woman with no family history of psychiatric illness was first admitted with psychotic symptoms in 1977. The initial diagnosis of manic–depressive psychosis was revised to schizophrenia in 1984, after several more admissions, with good recovery between episodes. In September 1987 she sustained several fractures in falling from a first-floor window at the psychiatric after-care hostel where she lived. She may have been psychotic at the time, although this is not clearly documented. She exhibited no psychotic symptoms on the orthopaedic ward, and after four months was transferred to a psychiatric hospital pending discharge back to her hostel. After a week she reported auditory hallucinations and exhibited bizarre catatonic posturing. She went missing and was later found lying against a radiator having sustained 5% third-degree burns to her buttock and arm. She was transferred to the general hospital for treatment, including surgery, and for seven months there exhibited no psychotic symptoms, despite withdrawal of her regular antipsychotic medication, until eventually she became deluded and aggressive and was returned to the psychiatric hospital for a further five-month stay.

Physical assault has been suggested as an important treatment for mental disorders in ancient Indian medical texts. The reasons for such an improvement may be similar to those postulated for the repeated self-harm exhibited by habitual self-mutilators, i.e. increased plasma metenkephalins (Coid *et al*, 1983). Increased levels of prostaglandins and/or opioids, whether endogenous or prescribed as analgesics, may account for the apparent effect of burns upon the mental state. We are currently compiling a list of such patients who may then be studied more thoroughly, and would welcome details of similar patients from our colleagues.

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