persistent diurnal depressive mood state developed, and she was admitted to a psychiatric hospital. No physical or psychological explanation of her symptoms could be discovered, and she had no previous psychiatric history. By this time she had continued to take this same dose of cimetidine for six months. Reduction of cimetidine to 200 mgs b.d. produced some improvement in her symptoms, and two weeks after total discontinuation of cimetidine, all her psychiatric symptoms had completely disappeared and have not recurred.

Anxiety-depressive syndromes as a complication of cimetidine therapy are clearly of importance to the psychiatrist, particularly as the frequency of their occurrence is as yet unknown. This complication may also have relevance to recent studies of the biological basis of endogenous depression, where disturbances of histaminergic neurones have been thought to be aetiological. (Leader, Lancet, April 15, 1978).

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NECROPHILIA, MURDER AND HIGH INTELLIGENCE

DEAR SIR,

The case report concerning 'Necrophilia, Murder and High Intelligence' by N. P. Lancaster (*Journal*, June 1978, **132**, 605–8) is of great interest. Not the least aspect of interest is the comment that 'He disliked dead bodies and whilst nursing was stated to have tried to get others to lay out the dead. He had eventually left nursing because of his dislike of nursing old people'. This in a man who 'Apart from the murder and the two mortuary incidents (involving female corpses), (he) was not sexually perverted'.

Clearly the patient/prisoner has gross sexual psychopathology and this we suggest is indicated by his nursing history. In an article we have published, 'Homosexual Necrophilia' (Bartholomew *et al*, 1978) we quote from a review of the literature by Bierman (1962). In this review he states: 'Glauber (1953) showed how necrophilic fantasies may act as a deterrent to the study of medicine. Pomer (1959) demonstrated how necrophilic fantasies similarly contributed to a work inhibition in a pathologist'. The article by Pomer is entitled 'On Necrophilic Fantasies and Choice of Specialty in Medicine'. This raises some interesting speculations not only in terms of the whole of medicine but in the smaller field of psychiatric medicine. For example, do the four groups of psychiatric consultants delineated by Hafner, Lieberman and Crisp (1977) have significantly different (sexual) psychopathology which significantly determines the area of sub-specialization, e.g., geriatric or child psychiatry, and the therapeutic techniques practised, e.g., electro-convulsive or psychotherapy.

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DEAR SIR,

It appears that the outcome of Dr Lancaster's case (*Journal*, June 1978, **132**, 605–8) has satisfied neither him nor subsequent correspondents. Judging by his paper, a plea of diminished responsibility on the grounds of psychopathic disorder would be unacceptable to Dr Lancaster, and that his case had suffered from a confusional state or non-insane automatism was unacceptable to the prosecution psychiatrists (and the jury). Manslaughter on the grounds that the accused was unable to form intent might or might not have been successful, yet it must be remembered that unlike *Beard* or Dr Pierce James' example (*Journal*, January 1979, **134**, 125), Dr Lancaster's case remembered not only what he had done but also being aware of doing it at the time.

His description would probably be given the diagnosis of pathological intoxication by the early authors described by Banay (1944), which encompasses the symptoms Dr Fullerton (*Journal*, October