virtually no spontaneous activity, and needed prompting to attend to all aspects of her personal care. Her mood appeared flat but she denied any feelings of depression, pessimism or hopelessness, slept and ate normally, and there were no other signs suggestive of depression. Her mental state showed no improvement in the hospital environment over a 6-week period prior to treatment.

She had a previous history of hyperthyroidism and partial thyroidectomy many years earlier. Biochemical testing showed total T_4 131 nmol/l (normal range 60–170), free T_4 17 nmol/l (9–22), free T_3 8.1 pmol/l (4.6–8.2), and TSH 0.05 mu/l (0.4–5). A thyroid scintigram and ultrasound showed an active nodule in the thyroid remnant with suppression of activity in the remaining thyroid tissue. In view of the marked suppression of TSH a diagnosis of subclinical hyperthyroidism was made and she was treated with carbimazole 15 mg b.d. Steady improvement in her mental state was seen over the next 3 weeks, with increased physical activity, increased social and emotional responsiveness, and a subjective report of feeling healthier and more energetic. She proved able to care for herself once again, was discharged from hospital and has remained well since.

SAWIN, C. T., GELLER, A., WOLF, P. A., *et al* (1994) Low serum thyrotropin concentrations as a risk factor for atrial fibrillation in older persons. *New England Journal of Medicine*, **331**, 1249–1252.

SCHLOTE, B., NOWOTNY, B., SCHAAF, L., *et al* (1992) Subclinical hyperthyroidism: physical and mental state of patients. *European Archives of Psychiatry and Clinical Neuroscience*, **241**, 357–364.

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Antidepressants in pregnancy and breastfeeding

SIR: We were interested to read the letter by Kent & Laidlaw (1995) about withdrawal symptoms in a baby who had been breastfed by a mother taking sertraline.

We report a 32-year-old woman who was started on sertraline 150 mg daily when 20 weeks pregnant. She delivered a healthy baby at term and breastfed for 11 days while on the same dose. There was no behavioural change in the baby after cessation of breastfeeding. Perhaps the appearance of withdrawal symptoms is dose related in that our patient was taking sertraline 150 mg daily while Kent & Laidlaw's patient was on 200 mg.

In the absence of controlled studies on the use of most antidepressants in pregnancy and breastfeeding, it would be useful if there were a register of cases where an antidepressant had been used and of the outcome. The setting up of such a register is under consideration by the Marce Society: International Association for Psychiatric Disorders of Childbearing.

KENT, L. S. W. & LAIDLAW, J. D. D. (1995) Suspected congenital sertraline dependence (letter). *British Journal of Psychiatry*, **167**, 412–413.

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Neuropsychological function in manic-depressive psychosis

SIR: McKay *et al*'s study (1995) requires comment. It does not appear that the three groups described by the authors are entirely comparable. The impaired group had 9 out of the 10 cases with bipolar affective disorder, whereas the ratio for the younger group was 2 out of 22 and for the elderly group 1 out of 11. If comparability is assumed then an assumption also needs to be made that the underlying disease process in bipolar affective disorder and major depression is identical. This is important because impairment was predominantly a feature of the bipolar group.

If cognitive impairment is a feature of the severe and chronic state, then it is also reasonable to speculate that a spectrum of neuropsychological deficit exists that increases with increasing chronicity and severity, although no such evidence was found in this study. Incidentally neither chronicity nor severity were defined. Presumably chronicity was determined on the basis of the number of years of illness but severity is harder to understand. Was it on the basis of number of symptoms, intensity of symptoms, or the level of care required? Hopefully selection was based on identical criteria.

While the authors dismiss drug effects by citing studies that report on the effect of drugs on cognitive function while the drugs are used individually, in clinical practice that is not the case. Chronicity and severity easily translates as intractability, implying that drugs are used in combination, at more than the usual doses and for prolonged periods of

time. The effects of the above cannot be ruled out.

Undoubtedly, with their excellent study design the authors have proved that cognitive impairment occurs in chronically ill bipolar affective disorder patients, but whether this reflects an integral part of the disease process remains to be determined.

McKay, A. P., Tarbuck, A. F., Shapleske, J., *et al* (1995) Neuropsychological function in manic-depressive psychosis. *British Journal of Psychiatry*, **167**, 51–57.

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Visual fields in Gilles de la Tourette Syndrome

Sir: Gilles de la Tourette (GTS) is a complex disorder characterised by multiple motor and one or more vocal tics (DSM–III–R; APA, 1987). It has been shown that GTS is a genetic disorder and the inheritance pattern is consistent with autosomal dominant transmission with incomplete but high penetrance (Eapen, 1993). In such a disorder there is always a quest for biological markers. Enoch *et al* (1988) described anomalous kinetic visual fields in 100% of children with GTS. It was suggested that visual field defects may serve as a genetic marker for GTS. Repka & Singer (1992) performed automated static perimetry on 18 children with GTS. They demonstrated field defects in 25% of cases, however, they observed that these rates approximated to those observed in patients undergoing first time visual field testing.

We undertook a prospective controlled study to which 12 GTS patients (24 eyes), and 12 (24 eyes) age, sex-matched controls were recruited. No ocular disease was detected in any of the subjects, none had previously undergone visual field testing. Visual field tests were performed using a Humphrey Field Analyser running a central 24-2 full threshold test. Data collected included mean deviation (MD) scores, an indication of the overall field abnormality and corrected pattern standard deviation (CPSD) scores, localised field defects. Twenty-one out of 24 visual field tests in each group were reliable according to the reliability indices built into the field analyser software and were included in statistical analysis. There were no statistically significant differences in either MD ($P=0.08$) or CPSD ($P=0.21$) between GTS and control eyes (see Table 1 for results for Humphrey fields). The difference in MD approached significance, and a larger sample might be expected to yield a significant result. However, the MD score for a particular patient would not serve as a biological marker for GTS since there is a large overlap of MD scores in the GTS and control groups. Our study indicates a trend for a higher negative MD score in GTS patients, but we conclude that visual fields do not serve as a useful biological marker.

American Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised) (DSM–III–R). Washington, DC: APA.

Table 1
Results of Humphrey 24-2 fields

	GTS patients					Controls			
	MD		CPSD			MD		CPSD	
Sex/Age	R eye	L eye	R eye	L eye	Sex/Age	R eye	L eye	R eye	L eye
M 22 y	−2.70	−2.02	0.00	0.00	M 23 y	−1.68	−1.64	0.00	0.92
F 46 y	−3.22	−2.33*	2.50	0.00*	F 44 y	0.08	0.16	1.12	0.00
F 51 y	−2.27	−2.36	0.00	4.06	F 50 y	−2.84	−4.63	0.00	5.48
M 23 y	−9.72	−13.9*	7.27	9.60*	M 24 y	−1.46	−1.38	0.00	0.00
M 50 y	−0.70	−1.66	1.38	0.00	M 46 y	−0.24*	0.63	0.52*	0.00
F 52 y	−2.78*	−1.67	1.07*	0.00	F 51 y	−0.77	−1.25	0.00	0.00
M 20 y	−3.40	−1.92	0.00	1.43	M 23 y	−1.29	−1.17	0.39	0.00
F 29 y	−1.69	−2.55	0.00	1.79	F 22 y	−0.78	−1.17	0.60	1.23
M 21 y	−2.10	−0.96	1.26	1.79	M 21 y	−2.33	−0.53	0.00	1.45
M 29 y	−2.58	−2.08	0.97	0.00	M 32 y	−1.26	−0.40*	1.11	1.34*
M 50 y	−2.10	−0.96	1.26	1.79	M 48 y	−1.78	−2.53	1.32	0.00
F 31 y	−3.25	−3.21	0.20	0.00	F 32 y	−8.39	−7.86*	3.75	4.56*

*low reliability score (excluded from statistical analysis).

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