This problem has been discussed and argued frequently by psychiatrists, but I have no doubt that most would agree with your broad classification of depressions into reactive and endogenous. The evidence that these are two entirely different diseases is very strong. They differ clinically in that the endogenous depressive rarely uses the term "depressed." He complains more of apathy, lack of feeling, or loss of interest. He may be retarded in thought, speech, drive, and ability to make decisions—symptoms not found in the reactive depressive. Furthermore, the endogenous depressive is frequently deluded, the delusions being of guilt, forthcoming punishment, ruin, disease, poverty, failure, and his own misdeeds. Delusions are never found in reactive depressions. The endogenous depressive tends to blame himself for his condition, which he does not recognize as an illness. The reactive depressive, on the other hand, fully realizes that he is ill, and seeks medical advice. The endogenous depression is often worse in the mornings. The patient tends to awaken early in the morning in an agitated, restless, and particularly depressed state. The reactive depressive, on the other hand, sleeps late, but has difficulty in getting off to sleep.

Perhaps the most obvious difference is the

observations and leads to more accurate and precise clinical medicine. I think the same holds true for psychiatry.—I am, etc.,

London W.1.

S. BOCKNER.

SIR,—I would like to make the suggestion, arising from reading your leading article "Drugs for Depression" (29 August, p. 522), that since, as you correctly state, reactive factors may be present in both "endogenous" and "reactive" depression it would be better to abandon your terminology and use classical and non-classical instead.

I am studying a group of patients referred for out-patient electroplexy (E.C.T.) at St. Thomas's. I have called those classical depression who show insomnia with early waking, symptoms worse in the morning, agitation and/or retardation, loss of concentration, energy, etc., with thoughts of unworthiness or self-reproach. All patients who do not show this picture were called non-classical depression. Reactive factors and the degree of response to out-patient E.C.T. were recorded *independently* of the clinical subdivision. The following results were obtained:

Type of Depression	Totals	Response to Out-patient E.C.T.				Reactive Factors
		Excellent	Good	Slight	Nil or Worse	
Classical	109	35	40	18	16	52 (47.7%)
Non-classical .. .	117	8	33	46	30	58 (49.6%)
Totals .. .	226	43	73	64	46	

$$\chi^2 = 33.9. \quad 3 \text{ d.f.} \quad P < 0.0005.$$

entirely different affect or mood in the two conditions. The reactive depressive feels miserable and despondent, in the ordinary sense that we all feel at times, whereas the endogenous depressive has a new and entirely novel feeling. The term "depression" in endogenous depression is misleading and not descriptive of the mood as the normal person knows it. The mood has a special and abnormal quality, so that relatives note a change in the whole person, both in appearance and behaviour. The patients do not cry, as the depressed neurotic does, frequently and copiously.

Not only do these two conditions differ in symptoms, but they also have a different treatment and prognosis. Most endogenous depressions recover quickly with electroplexy (E.C.T.) and many respond to anti-depressive drugs. E.C.T. is generally valueless in reactive depressions, and drugs have only a limited value in these cases. It is quite clear that the difference between these illnesses is the difference between psychosis and neurosis. To suggest that there is a sliding scale with mild depression at one end and severe depression at the other is also to suggest that neurosis and psychosis are mild and severe forms of the same illness. Few would agree with this, and furthermore one frequently sees mild examples of both conditions.

These illnesses differ in their aetiology, symptomatology, prognosis, and treatment. What more is required to distinguish them as different diseases? In general medicine we carefully identify and separate different forms of similar diseases—e.g., the classification of nephritis. This disciplines our clinical

These results show the equivalence of reactive factors in both types, but the classical type of depression, as expected, shows a much greater response to E.C.T.

In more detailed subdivision of the material I have used the term "psychotic" depression only where there was gross loss of insight with or without depressive delusions. Manic-depressive is reserved for only those cases with definite manic swings—rare in out-patient work, about 5 in 300. The classification involutional was not used at all.

I would hesitate to start a discussion reminiscent of unimodality and bimodality in hypertension, but it seems possible in view of graded responsiveness to E.C.T. that there may be several further subdivisions of depression, distributed along different axes, and we should not cling to the simple dichotomy of endogenous and reactive.—I am, etc.,

ERIC D. WEST.

Department of Psychological
Medicine,
St. Thomas's Hospital,
London S.E.1.

Buccal Oxytocin

SIR,—Your leading article on "Buccal Oxytocin" (19 September, p. 705) prudently draws attention to the necessity in using buccal oxytocin for the same close and continuous observation of the patient in a fully equipped hospital maternity unit as is required when oxytocin is given by the intravenous route. When giving intravenous oxytocin the

dose may be controlled with precision (as with the Palmer infusion pump) and altered according to the nature of uterine response. The effect is immediate and control is complete. With buccal oxytocin, on the other hand, when the mouth may contain up to 800 units oxytocin, absorption is beyond control. In spite of the closest observation of the patient there can be no control of the effect once absorption from the mouth has taken place. The knowledge that uterine activity falls by 50% within 15 minutes of withdrawal of oxytocin tablets,¹ far from being a comfort, must be regarded as a positive indictment of the method. Uterine hyper-tonus of a very few minutes' duration can produce devastating results. Apart from killing the foetus or causing permanent damage it may cost the mother her life. The close observation of the patient taking buccal oxytocin can only be aimed at the recognition of the dangerous complications of the method and will do little in the way of preventing them. The introduction of buccal oxytocin must surely be regarded as a retrograde step in obstetrics.—I am, etc.,

Department of Obstetrics
and Gynaecology,
Jessop Hospital for Women,
Sheffield 3.

F. A. BEST.

REFERENCE

- ¹ Elstein, M., and Wright, H. P., *J. Obstet. Gynaec. Brit. Cwlth*, 1963, **70**, 1005.

Propranolol for Angina

SIR,—One must feel some doubt about the validity of the conclusions reached by Dr. J. Hamer and his colleagues (19 September, p. 720) when they allude to the efficacy of intravenous propranolol in improving the effort tolerance of patients with angina pectoris. They show that of thirteen patients who were limited in their exertions by angina before the administration of this drug five remained free from angina and eight required greater effort to cause angina immediately after the drug was given. They do not advert at any stage to the well-known effect of exertion in temporarily increasing the effort tolerance of patients with effort angina. In my experience the case of classical "second wind" angina is not uncommon, but I would suggest that some degree of "second wind" is to be found in nearly all patients with this coronary syndrome. What results might be expected under the same circumstances in these patients if sterile water were administered instead of propranolol?—I am, etc.,

Dublin 4.

RISTEARD MULCAHY.

Excessive Consumption of Drugs

SIR,—At a time when the overall drug consumption rate is rising, awareness of interaction between various medicaments is increasing, and attention is rightly focused on illicit and excessive drug taking, the following cases and observations seem noteworthy.

A man aged 54, being treated for a chronic anxiety state, became ataxic and clouded mentally. Investigation and inquiry led to the detection of a serum-bromide level of 235 mg. per 100 ml. (the normal serum content being