Renaming the term schizophrenia in Japan

Sir—The members of the official Committee for the Renaming the Term Schizophrenia in Japan were bewildered at E Desapriya and N Iwase's letter (May 25, p 1866)[1] on terms for schizophrenia in Japan.

I write on the committee's behalf to say that the inaccuracies in their letter may be explained by the fact that they are not members of the Japanese Society of Psychiatry and Neurology (analogous to the UK Royal College of Psychiatrists) or of the World Psychiatric Association anti-stigma committee. They have not been involved in the long conceptual and empirical struggle to achieve a change of the Japanese term *Seishin Bunretsu Byo* (disease of split and disorganised mind) into *Togo-Shicchou-Sho* (a transient state of loosened association).

The true version of the events shows that before a decision was taken to change the name, national and international consultations were widely held.

In 1997 and 2000, symposia were held at the meetings of the Japanese Society of Psychiatry and Neurology to analyse the extent of the problem and the feasibility of a change. The ten papers presented were published in the official journal of the society.

In 1999, a symposium was held at the Hamburg Congress of the World Psychiatric Association Congress to enable discussion of the issue at international level. Christoph Mundt of Germany, Christian Scharfetter of Switzerland, and Ian Brockington of the UK presented papers that have since been published in the journal of the society.

To canvas the opinion of Japanese psychiatrists in general, The Official Committee did two questionnaire surveys (1996 and 1997). The results have been published in Japanese and English.[2] The historical and conceptual features of this complex problem were also explored by G E Berrios from the UK, and I.[3]

The Official Committee finds it very puzzling that Desapriya and Iwase choose to ignore the academic activities, search for consensus, and analysis of these complex issues. They can only surmise that it has been based on second-hand speculation and newspaper reports.

The official enactment of the change of name will take place at the World Psychiatric Association Congress at Yokohama, Japan, in August, 2002. The medical press will be sent an official communiqué from the Society.

The decision to change was not a harebrained scheme concocted in a backroom in Japan, but the result of a long-term national study. The study was made to dovetail with the international WHO and World Psychiatric Association programme against the stigmatisation of schizophrenia, which counts on the full support and participation of the society of families of people with schizophrenia.

Members of the Committee of Renaming the Term Schizophrenia are Mitsumoto Sato (chairman), T Iwadate, Y Kawamuro, Y Nishimura, K Moriyama, Y Ono, I Oshima, S Takagi, and S Ushijima.

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1 Desapriya EBR, Iwase N. Stigma of mental illness in Japan. *Lancet* 2002; **359:** 1886.
2 Ono Y, Satsumi Y, Kim Y, et al. Schizophrenia: is it time to replace the term? *Psychiatry Clin Neurosci* 1999; **53:** 335–41.
3 Kim Y, Berrios GE. Impact of the term schizophrenia in the culture of ideograph. *Schizophrenia Bull* 2001; **27:** 181–85.

Hypothyroidism in house officers

Sir—Among house officers currently in training in paediatrics at Duke University Medical Center, USA of whom 44 are women, three (7%) women were diagnosed with hypothyroidism during their residency. Diagnosis was delayed in two house officers because they attributed their symptoms to the adverse health consequences of postgraduate medical education—both can cause chronic fatigue, weight gain, constipation, depression, and deconditioning.[1]

Progression of symptoms was noticed by colleagues, who encouraged them to seek medical attention, but it was not until their fatigue persisted after their internship that they were persuaded to be assessed. After treatment, their symptoms, including their extreme fatigue, resolved. To their credit, the two house officers met their responsibilities while hypothyroid, although it must have been more difficult for them to do so than for others.

In retrospect, the two women thought they had been symptomatic for most of their internship year. The third house officer, who had fatigue, cold intolerance, and constipation, sought medical attention for milder symptoms because hypothyroidism had been diagnosed in her two colleagues. She was diagnosed with mildly symptomatic subclinical hypothyroidism.

The American Thyroid Association has recommended that thyrotropin (TSH) screening be started at age 35 years, especially in women.[2] The cases we report show that hypothyroidism is not rare in younger adults as well. Undoubtedly, this small cluster of cases is a chance occurrence, but it does highlight that the symptoms of hypothyroidism may be difficult to recognise by people working in demanding professions, even if physicians.

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1 Lindsay RS, Toft AD. Hypothyroidism. *Lancet* 1997; **349:** 413–17.
2 Ladenson PW, Singer PA, Ain KB, et al. American Thyroid Association guidelines for detection of thyroid dysfunction. *Arch Intern Med* 2000; **160:** 1573–75.

Pelvic sites of recurrence in rectal cancer

Sir—Concerns have been raised about harmful effects of radiotherapy, especially in older patients. In one meta-analysis,[1] the researchers concluded this risk may in part be caused by outdated radiotherapy techniques since parallel opposed field arrangements had been used in many of the studies assessed.

Use of a more advanced treatment set-up, such as conformal radiotherapy, with which the optimum target volume for adjuvant radiotherapy is defined, is essential to reduce side-effects without compromising efficacy, since salvage in recurrent disease is seldom achievable.[2] Precise data on pelvic sites of recurrence are rare and sometimes outdated because major changes in operative procedures have been adopted in the past few years.[3–5]

We have analysed the location of recurrent rectal cancer in the pelvis in 122 patients with a three-dimensional CT-based data-file system. To be included, patients had to have one of the major criteria—histological confirmation of recurrent disease, clear evidence of bone destruction on CT or MRI, or a positive positron-emission tomography scan—or at least three of the following minor criteria: