Bipolar disorder

National Cavanagh replies:
Having read Wu's reply to my earlier criticism I still think that this case should not be regarded as anything more than “suspected triphenyltin intoxication”. There are too many uncertainties for the conclusions to be anything more. One: a certain 100% certainty is the remarkably slow though sustained evolution of the signs of change in the nervous system. While ataxia and blurred vision were early in November, it was not until two weeks before he slipped into semicoma in November and lay in coma virtually until the beginning of February. Signs of peripheral neuropathy developed two months after admission and progressed for several months more. The pattern of the neuropathy suggested an axonal mechanism whereas the electrophysiology gave evidence of myelin loss. Another uncertainty is the dose the subject absorbed, which is unknown, nor do we have any blood concentrations. Although it might seem from the reports that animal studies support the suggestion that triphenyltin can be neurotoxic, when such studies are unaccompanied by thorough morphological work interpretation is always very difficult and experience strongly suggests that they should be taken with the proverbial pinch of salt, especially when they have not been confirmed by others.

Triphenyltin compounds are widely used in the field and are generally considered to be free of serious neurological side effects, unlike trimethyl- and triethyl compounds each of which produces its own pattern of affected cell types. On available evidence it is to be doubted whether there will be any future occasion when the claim of Wu and his colleagues will be supported, but should this happen I am content that this discussion and my initial reservations will be quoted.

J P CAVANAGH

NOTICES

Stanley Foundation Research Awards Program

Announcement of available research funds for research on schizophrenia and bipolar disorder

The Theodore and Vada Stanley Foundation, in collaboration with the National Alliance for the Mentally Ill, welcome applications for the 1996 Stanley Foundation Research Awards Program. The purpose of the awards is to support research directly related to the causes or treatment of schizophrenia and bipolar disorder.

The research awards are intended to attract established scientists from other areas of biology and medicine (for example, biochemistry, immunology, virology, and neurology) into research on schizophrenia and bipolar disorder as well as to provide support for innovative research by scientists already in the field whose funding sources are limited. Applicants are invited from all stages of career development.

Awards are for one or two years. Their value may be up to $75,000 per year for studies involving human subjects and up to $50,000 per year for other studies. Funds may be used for salaries, supplies, and equipment, but it is the policy of the Stanley Foundation not to pay indirect costs for administration of the award. In 1995, 49 applications were funded out of a total of 220 received.

Deadline for receipt of applications is 1 March 1996. The 4-page application consists of a brief statement of the work in progress, a budget, and a list of current and pending sources of funding. Notification of awards is made in June and funding to award recipients begins in August.

The research award applications are reviewed by a professional selection committee.

Requests for applications and questions should be directed to: Research Awards Coordinator, Stanley Foundation Research Awards Program, c/o NAMI, 200 North Glebe Road, Suite 1015, Arlington, VA 22203-3754, USA. Tel (703) 524-7600; fax (703) 524-9094

Sixth Meeting of the European Neurological Society June 8–12 1996


Administrative Secretariat ENS 1996, c/o AKM Congress Service, PO Box, 40011, Basel, Switzerland, Tel ++41 61 691 51 11, Fax: ++41 691 81 89.

British Neurosurgery Research Group Meeting together with the North American Research Society of Neurological Surgeons Meeting, 1996.

This joint meeting will be held in Newcastle upon Tyne, 23–25 May 1996.

For further information contact: Professor A David Mendelow, Newcastle General Hospital, Westgate Road, Newcastle upon Tyne NE4 6BE, UK.

CORRECTIONS


The reference to Osborne et al should be BMJ 1994;308:113.


In table 2 (bottom line) the mean R2 index (range) in the third EMG subclass should be 31 (28–37).