

article, we chose to follow specific a priori criteria for establishing that in these patients a manic syndrome was secondary to HIV infection. These criteria included the fact that the patients presented with a characteristic manic syndrome and demonstrated coexisting or emerging cognitive impairment. Additionally, there was laboratory evidence of active cerebral disease, as well as evidence of active immunosuppression. Furthermore, we evaluated the patients comprehensively for other causes of secondary mania, although given the space limitations we did not describe all the negative testing or unrevealing assessments. We could identify no well-established cause of a secondary affective disorder other than HIV infection in these patients. This search included consideration of prescribed medicines, over-the-counter medications, and substances of abuse. Additionally, secondary infections and other medical causes of mania were excluded.

Regarding the comments by Dr. Holmes, zidovudine has not been convincingly shown to cause a secondary mania. The reference cited by Dr. Holmes was a letter to the editor that presented two case reports. It would be difficult to establish a causal relationship based on these limited data. In our patient, there was certainly no temporal relationship between zidovudine therapy and the development of manic symptoms. Additionally, the one patient who began taking zidovudine during hospitalization for the manic syndrome showed no adverse effects from this medication. In response to Dr. Holmes' other question, five patients had a prior history of an affective disorder, as stated in the article. Four of these patients had been treated with antidepressants in the past, but at the time of their manic syndromes none of the patients was receiving such therapy. Four of these same five patients also had family histories of affective disorder, with depression in three families and a history of bipolar disorder in one.

Regarding the comments by Dr. Whitefield and associates, all patients were screened for drugs of abuse. Similarly, all patients were tested for the presence of syphilis. Admittedly, these tests may be imperfect; however, the laboratory tests were only one element in our clinical evaluation of each subject. On the basis of our examination and knowledge of these patients, we could find no evidence that their mania was caused by cocaine abuse or syphilis. All of these patients were well known either by colleagues or the authors before their psychiatric inpatient admission, or they were followed after discharge. No clinical data have substantiated an abuse-related etiology for their mania. Furthermore, the likelihood of these tests being falsely negative for the entire group of eight patients was particularly unlikely.

Our data did not support the recommendation that patients with mania be tested for HIV routinely. All of the patients we described had progressed to AIDS by the time their mania developed. Their primary diagnosis of HIV infection was obvious due to their opportunistic diseases. It has not been our experience that the manic syndrome occurs early in HIV infection or in otherwise asymptomatic patients.

We also strongly advocate the vigorous search for other secondary causes of mania before concluding that a patient with AIDS has mania due to HIV infection. It has been our experience that there is usually additional evidence supporting this diagnosis, e.g., meningeal enhancement on magnetic resonance imaging or emerging cognitive impairment. Thus, patients should fulfill the full array of criteria for establishing a secondary syndrome before concluding that their mania is due to HIV infection.

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Blunting of Clonidine-Stimulated Growth Hormone Release in Mania

SIR: In their excellent article showing blunted growth hormone (GH) stimulation in response to desipramine, Timothy G. Dinan, M.D., M.A., and associates (1) stated that to their knowledge, GH responses to noradrenergic challenges have not been previously investigated in mania. In fact, my colleagues and I have already shown a similarly blunted GH response to clonidine (0.15 mg i.v.) in seven drug-free manic patients age- and sex-matched to seven inpatients with major depression and seven with minor depression (2). The mean GH peak was similar in the manic patients (3.2 ng/ml, SD=2.4) and in the patients with major depression (3.2 ng/ml, SD=2.4) and significantly lower than in the subjects with minor depression (13.2 ng/ml, SD=8.7).

Results of these two studies support the hypothesis that α_2 -receptor abnormalities represent a trait marker for affective disorder. Another important consideration in interpreting these results is that the increased receptor sensitivity hypothesized to be related to mania (3) would be expected to peak in the later phases of bipolar depression before the "switch" to mania and to attenuate after the onset of the manic episode as receptors down-regulate in response to increased catecholaminergic availability. In fact, the only suggestion of augmented GH responses to clonidine challenge has been found in bipolar depressed patients (4). Therefore, the results of these two studies do not suggest sustained increases in α_2 -adrenergic receptor sensitivity in mania but cannot address the apparently more physiologic hypothesis advanced by Bunney et al. (3) that receptor increases precede the "switch" to mania, since the patients were evaluated at least several weeks after the onset of the manic episode. Obviously, the evaluation of the "switch" hypothesis needs longitudinal studies of bipolar patients.

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Challenge for Psychiatry

SIR: The editorial by Allan Beigel, M.D. (1) was timely. It brought to our attention how our profession can be used by government for motivations other than patients' care. The beauty of the editorial, if I understood it correctly, is that while recognizing the plight of our colleagues in Eastern Europe who worked for years under the Communist ideology, it also called