

It is likely (Dally, 1969) that many such patients do not seek, or even actively avoid, in-patient treatment and in these circumstances the prescription of 5HT re-uptake blocking drugs may prove to be of considerable value in their academic and social functioning, although not in their core anorexic psychopathology.

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#### Zinc in Senile Dementia

SIR: McLoughlin (*Journal*, March 1987, **150**, 409) appears to have selected information from various studies quoted by Srinivasan (1984) and concluded that lower zinc levels are present in the elderly functionally ill and in those with confusion. These studies cover a wide range of diagnoses and relate both to adult and psychogeriatric populations.

Our paper clearly describes the work of Bunker *et al* (1984), who suggest that the mean level of plasma zinc in healthy elderly adults is 11  $\mu\text{mol/litre}$  (s.d. = 1.2). The levels reported in our study compare well with Bunker's elderly group. It is reasonable, therefore, to imply that the low levels of zinc in senile dementia which McLoughlin suggests he would have demonstrated using a healthy elderly control group would not have materialised.

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#### Life Events and Mania

SIR: We are surprised that the *Journal* published an article which purports to measure life events prior to the onset of mania (*Journal*, February 1987, **150**, 235–240) when the method of life event assessment is simply that of searching case notes. Ambelas makes some important deductions from his assessment of life events, but we believe that the weakness of the life event assessment method is such that these could be misleading.

We are in the early stages of measuring life events prior to the onset of mania and are using the reliable method of Brown & Harris (1978) (LEDS). After assessment of only 11 patients two factors have become clear. Firstly, in the year prior to onset of mania 26 life events (according to the LEDS) have been elicited at interview, but only two of these were recorded in case notes. Secondly, the time between onset of symptoms and admission varied between 2 and 90 days (median 13 days), which indicates that measuring life events prior to admission, as performed by Ambelas, could be grossly misleading as there will be many illness-related events following the onset of a manic illness.

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#### Khat-Induced Paranoid Psychosis

SIR: In February 1984 we reported (Gough & Cookson, 1984) a case of khat-induced psychosis in a 27-year-old man originally from North Yemen who presented with paranoid delusions and thought broadcasting similar in nature to those described by Critchlow & Seifert (*Journal*, February 1987, **150**, 247–249). In our patient a urine drug screen at admission was positive for amphetamines but negative for opioids, cannabinoids, cocaine metabolites, and barbiturates. This is to be expected, as khat contains a number of amphetamine-like substances such as d-norpseudoephedrine.

Our patient's family stated that khat is widely used by Yemeni people in Liverpool, fresh supplies being flown in daily. It commonly produces some degree of elation and hyperactivity, but not frank psychotic symptoms.

In January 1985 we were contacted by journalists from *The Sunday Times* (20 January 1985) in connection with an investigation they were carrying out into the use of khat in Britain. They had found out that large quantities of the substance were being imported into London without restriction.

The Regional Drug Information Service informs us that no further cases have come to light in Liverpool, and it would appear that at present the use of the drug is mainly confined to certain ethnic communities. Possibly because of this it may be less likely to come to the attention of medical services.

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GOUGH, S. P. & COOKSON, I. B. (1984) Khat-induced schizophreniform psychosis in the UK. *The Lancet*, *i*, 455.

SIR: This case report (Critchlow & Siefert, *Journal*, February 1987, **150**, 247–249) does not accurately describe a typical case of khat psychosis. We reported three cases of catha (khat) psychosis (Dhadphale *et al.*, 1981): our patients had paranoid psychosis with florid delusions which occurred in clear consciousness, and excessive use of khat was suspected as a possible causal agent. In a five year follow-up we did not find any relapse of psychosis in our subjects. Since then we have seen more than a dozen patients with khat psychosis, and all of them have shown a similar clinical picture as well as outcome.

As khat chewing is blamed for every social evil in our society by the lay press, our department has been involved in substantial research on various aspects of khat chewing (Omolo, 1985; Omolo & Dhadphale, 1987a). Our country grows and exports good quality khat leaves and a substantial number of our people in khat-growing areas chew khat for its amphetamine-like stimulant effect. Many use alcohol to counteract the sleeplessness which inevitably follows khat use (Omolo & Dhadphale, 1987b).

Critchlow & Seifert's case appears to us to be a mixed psychosis, probably toxic in origin, and due to several factors such as respiratory infection, possible morphine or dihydrocodeine use or abuse, or subtle malnutrition due to poor appetite and sleep deprivation – the latter two being the result of chewing khat. The authors should have inquired about the quantity of leaves chewed by the patient during the weeks prior to admission.

However, they have rightly alerted the medical and psychiatric communities in the UK to the possibility

of khat being involved when a young person presents with a paranoid psychosis. Evidence of khat use may be found if the clinician examines the oral cavity of the patient for evidence of ulcers or stained teeth, which are common among habitual users.

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#### Capgras' Syndrome in a Patient with Dementia

SIR: We report a patient who typifies some of the issues raised by Kumar (*Journal*, February 1987, **150**, 251).

*Case report:* A 79-year-old woman presented with a three-year history of the gradual onset of impaired memory. Two years after onset her husband was admitted to hospital for a few days for a minor operation. On his return he noticed that his wife made repeated references to her 'first' husband, whom she claimed had died some years before. She now referred to her husband as her second husband, despite acknowledging the very close resemblance in physical appearance, name, and profession between the two. Even though the husband could not convince her of his true identity, she showed no hostility towards him; as she said, "the new man is quite nice to be with". The husband's attempts to remind her of their earlier married life were always met with the reply: "but I was married to John in those days". At the time of presentation this belief had persisted unchanged for six months.

On examination, she had moderate impairment of memory for recent and remote events. She was mildly dysphasic and dyspraxic and could not name, or recognise as familiar, any of the subjects in a Famous Faces test. She did not score above chance level on a forced choice test of facial recognition. There was no evidence of depression or other abnormal beliefs, and her insight was limited to concern about her poor memory. CT brain scan revealed mild ventricular dilatation and sulcal widening but other investigations were normal, and a presumptive diagnosis of senile dementia of Alzheimer type was made.