prominent. Given these features it would seem most appropriate to have made a primary diagnosis of depression rather than 'dementia and depression'.

An important point demonstrated, though not discussed in this paper, is that tests such as the Mini Mental State Exam (Folstein *et al*, 1975), a score of less than 24 on which was used to diagnose dementia in this study, should not be used as diagnostic instruments although they are useful as measures of degree of cognitive impairment.

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Reference

FOLSTEIN, M., FOLSTEIN, S. & MCHUGH, P. (1975) "Mini Mental State" a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**, 189–98.

DRUG COMBINATIONS FOR CHRONIC DEPRESSION

DEAR SIR,

Barker and Eccleston (*Journal*, March 1984, **144**, 317–19) describe a chronically depressed woman who responded to the combination of lithium/phenelzine/L-tryptophan but developed severe sodium retention problems. When given lithium/tranylcypromine/L-tryptophan she was unable to sustain improvement until carbamazapine was added.

I would like to describe a further chronically depressed case treated with lithium/tranylcypromine/L-tryptophan who, unlike Barker and Eccleston's case, showed not only rapid but sustained improvement. The patient concerned was a 63-year-old woman who for 3 years had been chronically depressed and had received 12 courses of ECT and had failed to respond to the combinations amitriptyline/thioridazine, lithium/mianserin and lithium/tranylcypromine. During exacerbations she showed irritability, social withdrawal, negativism, sleep disturbance and profoundly depressed mood. After one week on lithium carbonate (800 mg nocte) alone, tranylcypromine and L-tryptophan were added. Tranylcypromine 20 mg/day was given for the first 10 days then increased to 30 mg/day. L-tryptophan was gradually increased from 2400 mg/day to 3200 mg/day over the first 3 days with an increase to 4800 mg/day at the 8th day.

Within 5 days she showed clear improvement and was quite normal after 10 days. Over the last 4 years she has been maintained on lithium carbonate (800 mg nocte), tranylcypromine (10 mg b.d.) and L-tryptophan (1200 mg q.i.d.) with only one episode of depression occurring when lithium was stopped during an episode of diarrhoea/vomiting. Apart from an unexplained episode of lithium toxicity she has not shown any major unwanted side-effects, and in particular none of the sodium retention problems described by Barker and Eccleston.

If, as Barker and Eccleston suggest, 5-HT mechanisms are involved and an elevation of brain 5-HT function occurs, mention should be made of the possibility of major unwanted effects in the CNS. Animals given the combination lithium/tranylcypromine or tranylcypromine/L-tryptophan show a characteristic syndrome of hyperactivity thought to be due to a spillover of 5-HT at the CNS synapse.

Pre-treatment with lithium potentiates the syndrome of tranylcypromine/L-tryptophan and the occurrence of such a syndrome has been considered as predictive of the antidepressant activity of the agents involved (Grahame-Smith, 1971; Grahame-Smith & Green, 1974) However, the syndrome could also be equated to the symptoms sometimes seen in patients treated with MAOI/L-tryptophan, namely myoclonus, hyperreflexia, ataxia, ocular muscle oscillation and drowsiness (Baloh *et al*, 1982; Pare, 1963).

It is likely that this combination of agents is capable of producing both therapeutic and major unwanted effects, and as dosage is relevant to the production of the animal hyperactivity syndrome it would appear prudent to commence this combined treatment using low doses of agents with careful watch for CNS symptoms.

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References

BALOH, R. W. & SPOONER, J. W. (1982) Myoclonus and Ocular Oscillations induced by L-Tryptophan. *Annals of Neurology*, **11**, 95–7.

GRAHAME-SMITH, D. G. (1971) Studies of vivo on the relationship between brain tryptophan, brain 5-HT synthesis and hyperactivity in rats treated with monoamine oxidase inhibitors and L-tryptophan. *Journal of Neurochemistry*, **13**, 1053–66.

—— GREEN, A. R. (1974) The role of brain 5-Hydroxytryptamine in the hyperactivity produced in rats by lithium and monoamine oxidase inhibition. *British Journal of Pharmacology*, **52**, 19–26.

PARE, C. M. B. (1963) Potentiation of monoamine-oxidase inhibitors by tryptophan. *Lancet, ii*, 527–8.

PROGRESSIVE SUPRANUCLEAR PALSY

DEAR SIR,

Progressive Supranuclear Palsy (PSP) is a rare, non-

familial, chronic progressive neurological disorder of middle and later life, of unknown aetiology, characterised by marked supranuclear opthalmoplegia affecting vertical eye movements initially, pseudobulbar palsy, dysarthria, dystonic rigidity of the neck and upper trunk, and dementia/frontal lobe syndrome (Price, 1978). Other cerebellar and pyramidal symptoms may occur (Lishman, 1978). PSP was first described by Steele, Richardson & J. Olszewski (1964) as a clinical syndrome separate from Parkinsonism, and is sometimes known as the Steele-Richardson-Olszewski syndrome. Diagnosis is mainly by clinical progression of the disease (Haldeman, Goldman, Hyde & Pribram, 1981). The largest reported series is by Jackson, Jankovic and Ford (1983) who found 16 cases of PSP in 415 patients with an initial diagnosis of Parkinsonism. We have been unable to find any case report in a British psychiatric journal in the last ten years.

A 48 year-old divorced woman with seven children was referred to a psychiatrist with a three year history of changing personality, depression, loss of weight, difficulty in speaking normally, increasing lack of competence in the home, occasional lapses of memory, a tendency to fall and difficulty in using her hands efficiently. She was admitted to a psychiatric ward for assessment. Mental state examination revealed no psychotic features, she was correctly orientated for time, place and person, and memory was apparently normal on testing. She had insight into the gradual changes in herself, and was distressed and depressed by them. She was referred to a neurologist, who detected severely impaired vertical eye movements, mask-like facies, axial rigidity, dystonia, dysarthria and hyper-reflexia. On the basis of these and her mental changes, the diagnosis of Steele-Richardson-Syndrome was made, supported by CT Scan (Jackson *et al* (1983), Haldeman *et al* (1981) which showed moderate cerebral atrophy.

During the next 9 months, the patient deteriorated rapidly. She became incontinent, disinhibited, often undressed in public, required to be bathed and dressed, fell frequently, and developed periodic inflammatory changes in her eyes. Nonetheless she remained fully orientated, and answered questions rationally. This combination of depression, disinhibition and need for nursing care, together with intact awareness of her surroundings and retained insight, created a management problem, as she was not appropriately placed in a general psychiatric ward, or psychogeriatric unit (at the age of 48). Special arrangements were made for her transfer to Part III Accommodation with Psychogeriatric Day Hospital attendance. Soon after her transfer she developed respiratory complications and was admitted to a general medical ward, where she died 11 days later. Death was attributed to pulmonary embolism. No post mortem was done.

The following features are of interest.

1. The case presented as a psychiatric disorder.
2. Although her behaviour suggested pre-senile dementia, cognitive functions and insight remained relatively intact, suggesting predominantly frontal lobe damage.
3. The age of onset was 45 (usual range 51–68 years, average 59.3 years) (Jackson *et al*, 1983).
4. The disease progressed rapidly to death 9 months after diagnosis (average duration 4.4 years (Lieberman *et al*, 1982) or 5.4 years (Jackson *et al*, 1983)).

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References

HALDEMAN, S., GOLDMAN, J. W., HYDE, J. & PRIBRAM, H. F. (1981) Progressive supranuclear palsy, computed tomography and response to antiparkinsonian drugs. *Neurology (NY)*, **31**, 442–5.

JACKSON, J. A., JANKOVIC, J. & FORD, J. (1983) Progressive supranuclear palsy: clinical features and response to treatment in 16 patients. *Annals of Neurology*, **13**, 273–8.

LISHMAN, W. A. (1978) Progressive supranuclear palsy (Steele-Richardson Syndrome). *Organic Psychiatry*. Oxford: Blackwell.

NEOPHYTIDES, A., LIEBERMAN, A. N., GOLDSTEIN, M., GOPINATHAN, G., LEIBOWITZ, M., BOCK, J. & WALKER, R. (1982) The use of lisuride, a potent dopamine and serotonin agonist, in the treatment of progressive supranuclear palsy. *Journal of Neurology, Neurosurgery and Psychiatry*, **45**, 261–3.

SCOTT, R. B. (ED.) (1978) *Price's Textbook of the Practice of Medicine* 12th Edition. Oxford University Press.

STEELE, J. C., RICHARDSON, J. C. & OLSZEWESKI, J. (1964) Progressive supranuclear palsy. *Archives of Neurology*, **10**, 333–59.

AGORAPHOBIA AND HYPERTHYROIDISM

DEAR SIR,

Having recently seen two patients with agoraphobic and thyrotoxic symptoms, I was struck by Dr Weller's letter (*Journal*, May 1984, **144**, 553–4) reporting this association. It is surprising that there seems to be no literature on this specific relationship at all, even though thyroid function tests are now mandatory (excessively so) in the assessment of anxiety states.

My first patient, a 41 year-old housewife, was treated for thyrotoxicosis between 1978 and February