visual hallucinosis are typical of the amphetamine psychosis first described by Connell (Maudsley Monograph 1958). This problem is a seriously under-reported side-effect of such drugs, and highlights the need for extreme caution in their use.

DEBORAH BROOKE
ROBERT KERWIN
KEITH LLOYD

The Maudsley Hospital
Denmark Hill
London SE5 8AZ

The Place of Benzodiazepines in Psychiatric Practice

SIR: I am concerned that, in spite of the provisos mentioned, the paper on benzodiazepines by Tyrer & Murphy (*Journal*, December 1987, **151**, 719–722) will, in effect make a further contribution towards inhibiting the judicious and careful use of these drugs in appropriate cases based on experienced clinical judgement. As the authors state, patients are already "being encouraged to sue doctors for making them dependent" (on benzodiazepines). A sense of proportion is surely required here.

There are still many patients with chronic anxiety symptoms who do not respond to expertly applied alternative therapeutic techniques and, especially if "over 50% can stop their medication without withdrawal problems" and "... from present evidence there is no unequivocal permanent handicap caused by benzodiazopines in short or long-term dosage", it seems to me that clinical psychiatrists should have the courage to publicise these points in a responsible manner so that the media in particular and the public in general are better informed on these important problems.

MAURICE SILVERMAN
Our Lady of Compassion Hospital
Preston New Road
Blackburn BB2 7BG

SIR: Our comment about the medical and legal implications of prescribing benzodiazepines was made to draw psychiatrists' attention to the image of benzodiazepines portrayed in the media. If patients are going to sue doctors for prescribing benzodiazepines, the profession needs to be appraised of this fact, if only to ensure that adequate records are kept of consultations involving drug prescription. Currently we know of some 400 patients in the United Kingdom who have approached solicitors because of problems they have had with benzodiazepines. We agree with Dr Silverman that it is right to draw attention to the benefits as well as the risks of benzodiazepines, but if the use of these drugs is injudicious and careless the consequences could be serious.

PETER TYRER
SIOBHAN MURPHY

Mapperley Hospital
Porchester Road
Nottingham NG3 6AA

Neurosyphilis and Psychiatry

SIR: In their recent report of a patient with neurosyphilis, Brooke *et al* (*Journal*, October 1987, **151**, 556) stress the importance of serological screening tests for syphilis in psychiatric patients whose mental state suggests an organic component. We have reviewed the cases of neurosyphilis presenting to the psychiatric unit of Tygerberg Hospital, the results of which serve to emphasise this view. Of 4314 consecutive admissions to the psychiatric unit between January 1983 and June 1987, 53 had a positive cerebrospinal fluid treponemal antibody absorption test. Thirty-two (0.74% of all admissions) satisfied criteria (Burke & Schaberg, 1985) for a diagnosis of neurosyphilis; of these, 16 were suffering from acute, treatable psychiatric conditions, namely delirium ($n=6$), mania ($n=5$), hallucinosis ($n=4$), and depression ($n=1$). These data suggest that, especially in developing countries such as South Africa, routine serological tests for syphilis in psychiatric patients remain essential.

R. A. EMSLEY
M. C. ROBERTS
E. A. HIGSON
J. J. F. TALJAARD

University of Stellenbosch
PO Box 63
Tygerberg 7505
South Africa

Reference

BURKE, J. M. & SCHABERG, D. R. (1985) Neurosyphilis in the antibiotic era. *Neurology*, **35**, 1368–1371.

Heterogeneity in Sporadic Schizophrenia

SIR: Lewis *et al* (*Journal*, September 1987, **151**, 306–314) have recently reviewed their original hypothesis (Murray *et al*, 1985) that the presence or absence of a family history identifies subgroups of greater aetiological homogeneity within schizophrenia. While their own data on ventricle brain ratios (VBR) in schizophrenic patients without a family history of major psychosis being larger than those with a family history (Reveley *et al*, 1984) are in support, results from other studies are not consistent

with this hypothesis (reviewed by Goldin *et al, Journal,* September 1987, **151,** 302–305). Goldin *et al* point out the problems with this methodology, in particular the definition of what constitutes sporadic schizophrenia, a sub-group that may be inherently heterogeneous. We have some data suggesting that the way we define this group affects the differences, if any, between familial and sporadic schizophrenias.

Eighteen consenting patients from the Bethlem Royal and the Maudsley Hospitals (mean age = 33.8 ± 10.8; 13 males and 7 females) were studied. All fulfilled RDC criteria (Spitzer *et al,* 1975) for schizophrenia. The mean duration of illness was 57.2 ± 45.8 months. Six patients were drug-free at the time of the study. None had any major systemic illness, current alcohol or drug abuse, or evidence of neurological disease. Family history of psychiatric illness was obtained from the patient and any available informant. A positive family history required either a hospital summary specifying a clinical diagnosis of schizophrenia or other psychiatric disorder, or a subject or informant volunteering both the diagnosis and a compatible history in a first-degree relative. Six subjects had a family history of schizophrenia in a first-degree relative, three had a family history of affective psychoses or depressive spectrum disorders, and nine subjects had no family history of psychopathology.

Patients were scanned without contrast using the Maudsley Hospital EMI 1010 CT scanner. Five or six contiguous 1 cm slices were taken parallel to the orbitomeatal line to encompass the whole ventricular system. Ventricle-brain ratios were measured using a semiautomated technique on the single slice with the largest-ventricular area (Reveley *et al,* 1982).

The mean VBR in the patient group as a whole was 4.63 (s.d. = 2.99, median = 4.3, range = 1.2–11.4). The non-familial sub-group ($n = 12$) had non-significantly larger VBR than the 6 subjects with a family history of schizophrenia (VBRs = 5.18 ± 3.2 and 3.5 ± 1.6 respectively; $t = 1.47$, NS). However, when the three patients who had a family history of affective disorders were excluded from the former group, the difference became modestly significant (VBRs = 5.85 ± 3.5 and 3.5 ± 1.6 respectively, $t = 1.8$, $P < 0.05$, one-tailed).

Our study was limited by the very small sample size, use of the family history method (which is inferior to the family interview method), and the use of a relatively young patient population which may have resulted in fewer relatives reaching the age of risk for psychiatric disorders. However, our data suggest that the familial sporadic distinction within schizophrenia may be more valid when a 'narrow' definition of sporadic and familial schizophrenias is used. Lewis *et al*'s succinct guidelines for assessment of family history will certainly help future studies intending to pursue their innovative hypothesis further.

M. S. KESHAVAN
Western Psychiatric Institution and Clinic
Pittsburgh, PA 15213
USA

BRIAN S. TOONE
King's College Hospital
London SE5

References

MURRAY, R. M., LEWIS, S. W. & REVELEY, A. M. (1985) Towards an aetiological classification of schizophrenia. *The Lancet, i,* 1023–1026.

REVELEY, A. M., REVELEY, M. A., CLIFFORD, C. A. & MURRAY, R. M. (1982) Cerebral ventricular size in twins discordant for schizophrenia. *The Lancet, i,* 540–541.

——, —— & MURRAY, R. M. (1984) Cerebral ventricular enlargement in non-genetic schizophrenia: a controlled twin study. *British Journal of Psychiatry,* **144,** 89–93.

SPITZER, R., ENDICOTT, J. & ROBBINS, E. (1975) *Research Diagnostic Criteria, Instrument No. 58.* New York: NY State Psychiatric Institute.

SIR: Kendler's group (Eaves *et al,* 1986; Kendler, 1987) have produced good statistical reasons to be circumspect about the power of the familial-sporadic distinction in small samples. Nevertheless, the majority of studies have shown a familial effect on VBR, and Drs Keshavan & Toone do so in a sample of only 18 patients. Although Drs Keshavan & Toone do not explicitly say so, they may have intentionally selected their patients to ensure equal numbers with and without a family history. This strategy would certainly have increased the power of the distinction. They also allude to young age as a factor which may have acted against them. On the contrary, young age may well increase the power of the familial-sporadic distinction. As more and more time elapses after the onset of schizophrenia, hospital in-patient samples will increasingly represent the poor outcome end of the spectrum. Should, as is likely, either VBR or family history influence outcome in schizophrenia, then the heterogeneity of these variables in hospital samples will therefore become less and less as time goes by. The way round this artificial attrition of heterogeneity with time would either be to confine studies to young patients who are in or near their first episode or to ensure epidemiological (not hospital-based) sampling.

Drs Keshavan & Toone's point about ensuring a 'narrow' definition of sporadic schizophrenia is well made. Certainly, cases with a history of affective disorder in a first-degree relative should not be considered 'sporadic'; the more interesting question is