THE VALUE OF ROUTINE X-RAYS IN DEMENTIA

DEAR SIR,

We read with interest Dr Larkin's article (*Journal,* **146,** January 1985, 62–65) on routine X-rays in psychiatric patients. We have made a similar audit of our X-ray procedures in patients with dementia.

Routine chest X-rays on 123 demented patients consecutively admitted to our hospital for assessment showed the following abnormalities: enlarged heart (15 cases), cardiac failure (12 cases), chronic obstructive airways disease (9 cases), chest infection (8 cases), old calcified lesion (2 cases), multiple rib fractures with an apical pneumothorax (1 case), fluid in both costophrenic angles (1 case) and hiatus hernia (1 case). Although the chest X-ray was of no value in the differential diagnosis of dementia in our series, cases of cryptic chest infection and cardiac failure were occasionally identified. We suggest that a routine chest X-ray is indicated not least for the recognition of these coincidental illnesses, treatment of which sometimes leads to an improvement in behaviour and in subsequent management of patients with primary dementia.

A skull X-ray performed in 120 of these patients revealed the following abnormalities: carotid syphon calcification (12 cases), calcification in the falx cerebri (1 case), lytic area of unknown origin in the occipital bone (1 case), osteoporosis (1 case) and Paget's disease (2 cases). These results were not particularly helpful in the diagnosis and management of our patients, which may support Dr Larkin's conclusion that skull X-rays should not form part of the routine assessment of psychiatric patients. However, if this guideline had been followed, a resectable meningioma would have been missed in a 62 year old woman with an eighteen month history of dementia and absent focal neurological signs. On rare occasions, bony changes on the skull X-ray may be the first indication of a meningioma or of metastases.

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KORO IN NON-CHINESE SUBJECTS

DEAR SIR,

I wonder whether Koro is as exotic or rare a phenomenon as the literature suggests. Certainly over the years I have seen patients who have desribed shrinkage of the penis in a setting of depression.

Victor Gollancz the publisher in his autobiographical musings to his grandson "More for Timothy" gives a vivid description of a Koro-like syndrome—"I was afflicted during most of 1943 and part of 1944 . . . There was not it is true, acute physical pain. But a dirty sort of pain, low, vague and indiscriminate, possessed the whole of my body, and made me abominable to my consciousness; and a more specialised phenomenon not only almost physically annihilated me whenever it appeared—and it appeared many times every day . . . For the instant I sat down . . . My member would disappear: I would feel it retiring into my body and would know myself . . . as not only unmanned, but dehumanised". He goes on to say, "I was utterly derelict and felt myself banished from life and from God. And I was quite hopeless".

This seems to be a description of a depressive illness with a delusional or over-valued idea in a man who had previously confessed in the first volume of his autobiography *My Dear Timothy* to masturbation guilt.

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References

GOLLANCZ, V. (1953) *More for Timothy*. London: Gollancz.
—— (1952) *My Dear Timothy*. London: Gollancz.

FALLING INCIDENCE OF SCHIZOPHRENIA?

DEAR SIR,

Eagles and Whalley (*Journal,* February 1985, **146,** 151–154) offer the intriguing conclusion that their results "probably reflect a genuine fall in incidence" in schizophrenia over the decade studied. Extrapolation of their data would suggest that Scotland at least will be rid of new cases of schizophrenia by 1944. Before policy makers begin planning for such an eventuality, it may be as well to take another look at more parsimonious explanations for these findings. The authors rightly acknowledge that, during the period they examined, two potent confounding factors were probably operating: the swing in diagnostic fashion away from schizophrenia and the increasing practice of community intervention and care. It may be that, as the authors claim, neither of these factors alone could sufficiently explain the decline in first admissions for schizophrenia in the observed absence of a concomitant change in the rates for paranoid states of mania. However, if one assumes, not unreasonably, that both these factors were at work simultaneously then they would surely conspire to produce precisely these data. Whilst each factor

acts to reduce the apparent incidence of schizophrenia, one would tend to increase, whilst the other diminish, the apparent incidence of other psychotic disorder.

The authors admit they are at a loss to offer a plausible mechanism for their interpretation, although they are evidently aware of its potential repercussions, especially in terms of the allocation of health services. In this regard, timely cuts from Occam's razor are less harmful than future cuts in already compromised services for the mentally ill.

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DE CLÉRAMBAULT'S SYNDROME—A NOSOLOGICAL ENTITY

Dr Ellis and Professor Mellsop's article (*Journal*, January 1985, **146**, 90–95) is a salutary exercise in diagnostic stringency. I would agree with them that it is likely that most cases described as erotomania are, in fact, suffering from a wider disorder such as schizophrenia, but I do not accept that the existence of primary erotomania can be summarily dismissed.

In my work on monosymptomatic hypochondriacal psychosis (MHP), I have encountered a similar situation. Many cases of delusional hypochondriasis prove to be secondary to other conditions, and when I began searching for primary cases I was told that they were excessively rare to the point of non-existence. Since there is now a growing literature apparently confirming the reality of the primary type, I am fairly satisfied that my recognition of it is not entirely delusional!

Several years ago, I was struck by the great similarity of the clinical picture in both MHP and pathological (paranoid) jealousy: the main difference lay in the delusional content. Again, paranoid jealousy may be seen in the "pure" or "primary" form, or may be secondary to other psychiatric illnesses. Two of my former residents and I have separately presented single case accounts in which primary paranoid jealousy responded well to pimozide, similarly to many cases of MHP (Dorian, 1979; Pollack, 1982; Munro, 1984).

More recently, after a long search, two colleagues and I identified two cases of primary erotomania, and successfully treated these with pimozide. Once more, the clinical picture is very like that of MHP, but this time the delusional content is one of erotic preoccupation. These patients are described in an article to be published by the *Canadian Journal of Psychiatry* (Munro, O'Brien & Ross, in press).

Cases of primary MHP, paranoid jealousy and erotomania fit very closely with Kraepelin's description of paranoia (Kraepelin, 1921). After his death, many psychiatrists denied that such a condition existed, but it has been rehabilitated and vindicated in recent years (Kendler, 1984) and I think that, until our present nosological system improves, we should place these three disorders under the rubric of paranoia. Incidentally, "primary" proves to be a relative term: I do my utmost to exclude cases with evidence of schizophrenia, affective disorder, organic brain disorder, obsessive-compulsive disorder, etc., but even so, I find that a history of substance and alcohol abuse (often non-current) is so common that I suspect that this may be an aetiological factor even in the primary presentation.

Dr Ellis and Professor Mellsop do us a service in encouraging us to be more careful in an area of diagnosis that remains tentative, but I do not accept as proven that cases of primary erotomania do not exist, although for the time being I shall accept that they seem rare.

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References

DORIAN, B. J. (1979) Monosymptomatic hypochondriacal psychosis. *Canadian Journal of Psychiatry*, **24**, 377.

POLLACK, B. G. (1982) Successful treatment of pathological jealousy with pimozide. *Canadian Journal of Psychiatry*, **27**, 86–87.

MUNRO, A. (1984) Excellent response of pathologic jealousy to pimozide. *Candian Medical Association Journal*, **131**, 852–853.

—— O'BRIEN, J. V., ROSS, D. Two cases of "pure" or "primary" erotomania successfully treated with pimozide. *Canadian Journal of Psychiatry*. In press.

KRAEPELIN, E. (1921) *Manic Depressive Insanity and Paranoia*, transl. R. M. Barclay (ed. G. M. Robertson). Edinburgh: Livingstone.

KENDLER, K. (1984) Paranoia (delusional disorder): a valid psychiatric entity. *Trends in Neurosciences*, **7**, 14–17.

THE PSYCHIATRIC INTENSIVE CARE UNIT

DEAR SIR,

I was interested in the article by Dr Goldney *et al* (*Journal*, January 1985, **146**, 50–54), describing a Psychiatric Intensive Care Unit in Adelaide, Australia, as I carried out a similar study of a new Psychiatric Intensive Care Unit at the North Wales Hospital, Denbigh, in 1982. The study looked at the admissions during the unit's first six months, using a questionnaire and microcomputer database. The