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Correspondence

Correspondents should note that space is limited and shorter letters have a greater chance of publication. The Editors reserve the right to cut letters and also to eliminate multitudinous references. Please try to be concise, strictly relevant and interesting to the reader, and check the accuracy of all **references in Journal style.**

CANCER AND DEPRESSION

DEAR SIR,

I read with interest Drs. Brown and Paraskevas article on cancer and depression (*Journal,* September 1982, **141,** 227–32). The association between depression and cancer is indeed strong and the suggestion of a possible immunologic link between the two entities is certainly appealing. The authors propose that antibodies against tumor-related proteins, because of cross-reactivity with CNS proteins that are conceivably identical to serotonin receptors, may interfere with the brain activity of serotonin and thus lead to depressive symptoms.

Although this is a reasonable hypothesis, there are conceivably other, more direct ways in which immune factors can provide the necessary link between depression and cancer. Preliminary data from our own laboratory (Kronfol *et al,* 1982) as well as others (Linn *et al,* 1982) suggest that depression may be associated with an impairment in cell-mediated immunity, elements of which are said to protect the organism against cancer (Penn, 1981). Since depressive symptoms usually antedate clinical manifestations of cancer, we therefore propose that depression may impair host defense mechanisms, thus allowing neoplastic cells to proliferate and spread out of control in certain predisposed individuals. The etiology of cancer is complex and still eludes our complete understanding.

Genetic predisposition, environmental factors, pharmacologic agents, hormones, diet and life style have all been suggested as possible contributing factors. When severe depression precedes cancer, the depressive illness may present an additional risk.

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PARANOIA AND DYSMORPHOPHOBIA

DEAR SIR,

I would like to reply to a comment made by Alastair Munro in his recent paper "Paranoia Re-visited" (*Journal,* October 1982, **141,** 344–49). He states "Many authors fail to differentiate between neurotic and psychotic disorders with rather similar complaints. For example dysmorphophobia should be by definition a non-psychotic illness but is often used to describe delusions of misshapenness (Hay, 1970)".

This view can only result from a basic misunderstanding of my paper. In that article I resurrected the term "dysmorphophobia" which had been used in the 19th century (Morselli, 1886) to describe those patients who present with "a fear of being mishapen" when in fact objectively they have no cause for a complaint. I remarked that dysmorphophobia is a symptom not a diagnosis or illness and was at pains to point out that after investigation the eventual diagnosis could vary from a sensitive personality development to an attenuated schizophrenic illness or even occasionally to affective disorder. In other words dysmorphophobia is non-specific as a symptom and can occur in a variety of different psychiatric syndromes.

We appear to be in danger of getting lost in a semantic quibble. If we choose to restrict the term dysmorphophobia to those patients whose symptom is purely personality based, there is nothing inherently wrong with that, but we would be using the term as diagnosis. Monosymptomatic hypochondriacal psychosis can be used to describe those patients whose complaint is delusional and there are certainly advantages in this somewhat cumbersome label in that it avoids using the word schizophrenia. What we do not know is how many of those patients, either the very sensitive personalities or those with monosymptomatic hypochondriacal psychosis, become schizophrenic with time. This question can only be settled by long term studies. I am at present following up the group of