

ischaemic attacks and, finally, in 1977, a stroke with a right hemiparesis which disappeared in a month. Three years later, in 1980, nine years after the diagnosis of polycythaemia rubra vera, she had her first depressive episode, with dysphoria, suicidal ideation, psychomotor retardation, persecutory delusions, loss of interest, weight loss, and anergia. No significant life events preceded its onset. Depression ran a chronic fluctuating course, with transient periods of improvement, until she was visited by us, in 1991, still depressed and paranoid. She had 9.9 million/mm³ RBCs, 14 000/mm³ WBCs and 900 000/mm³ platelets. She had been treated with different antidepressant, antipsychotic and anti-anxiety drugs. During the last two years polycythaemia had been treated with busulfan (an alkylating agent) and pentoxifylline, which did not change the course of her depression. Previously, she had been treated with aspirin.

Although depression is a well known complication of stroke, the appearance of depression in our case three years later, and its course, point against a causal relationship. Her depression appeared nine years after the diagnosis of polycythaemia and this points against a 'reactive' depression. Clearly, it is possible that the association between polycythaemia and psychotic depression in our case was casual; however, depression seems to be a not uncommon complication of polycythaemia rubra vera, according to the haematology literature cited by Murray & Hodgson.

MARCO MAZZOLI

Psychiatry Service
Public Hospital 'Morgagni'
47100 Forlì
Italy

FRANCO BENAZZI

via Pozzetto 17
48010 Castiglione de Cervia RA
Italy

Phobic disorders and benzodiazepines in the elderly

SIR: In his interesting paper Lindesay (*Journal*, October 1991, 159, 531–541) fails to consider the possibility that benzodiazepine drugs may have been the cause of the late-onset phobias in some of his patients. In 11 of 18 in whom the main fear began after the age of 65 years, it followed a physical event, and in five, some other traumatic exposure such as a mugging, a fall or being trapped in a lift. In all these situations it is not unusual (although of course wrong) for benzodiazepine drugs to be given, and not infrequently they continue to be given subsequently. Nineteen of Dr Lindesay's cases were taking psychotropic medication, most commonly a benzodiazepine, but we do not know from his data what the relationship of taking these drugs was to the onset or aggravation of the symptoms.

The natural history of anxiety symptoms following illnesses or trauma is towards natural resolution and when this does not happen one must always consider what may be keeping them going. In some patients, perhaps because of their individual vulnerability, the cause is benzodiazepine drugs and if this is the case these patients can be totally relieved of their symptoms. This problem arises at all ages and is illustrated by the following example in an elderly patient.

Case report. A lady of 75 had always been rather phobic of lifts and of trains but for two years she had suffered from severe anxiety, panic, terror and misery. This followed an operation on her knee, since when she had taken lorazepam 2 mg daily. She was so frightened that when travelling in the car with her husband she felt she wanted to jump out of the car if he stopped at traffic lights, and a measure of the intensity of this feeling was that her husband fixed a special lock on the door. She could not be left alone in the car while he went into a shop to buy a newspaper. Her tablets were stopped over a period of four weeks with suitable explanation of what to expect by way of withdrawal symptoms, and at the end of five weeks she said it had been "the worst five weeks of my life". At eight weeks there had been a few spells of feeling normal and at 12 weeks she had been in a lift although severe insomnia persisted. At 16 weeks she was completely well, happy and free of symptoms. She could sit in the car long enough for her husband to have his hair cut.

This is not a new idea. Ashton (1984) pointed out that many patients develop phobias for the first time after a period of regular benzodiazepine use and that these symptoms disappear when the drug is withdrawn. Her paper gives references to a similar view expressed previously by Lader, Tyrer and others. The above example is one among many such patients, *of all ages*, and although it is not always easy to wean patients from their tablets it can usually be done with appropriate support and explanation and these patients become some of the most grateful a psychiatrist can have.

ASHTON, H. (1984) Benzodiazepine withdrawal: an unfinished story. *British Medical Journal*, 288, 1135–1140.

SAMUEL I. COHEN

The London Hospital Medical College
Turner Street
London E1 2AD

NMS complicated by diazepam

SIR: Neuroleptic agents are used extensively in psychogeriatric practice, including the management of behavioural problems in Alzheimer's disease. Serby (1986) reported NMS in a patient with Alzheimer's disease. Finucane *et al* (1984) reported NMS in an 81-year-old man, induced by haloperidol. This communication pertains to a 67-year-old gentleman who