50 Years of Cocaine Addiction

SIR: Rollin's fascinating description of Sherlock Holmes (*Journal*, August 1988, **153**, 241–242) prompted us to put pen to paper. He writes that "mental or physical deterioration is the inevitable penalty of prolonged cocaine abuse." However, we have in our care a patient who has been addicted to cocaine for 50 years and has not suffered any physical, mental, or social deterioration during this period.

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Shoplifting as a Symptom of Stress in Families of Mentally Handicapped Persons: A Case Report

SIR: Roy (*Journal*, June 1988, **152**, 845–846) described a father of a severely handicapped school-leaver who began to shoplift in apparent response to his son's psychiatric symptoms. Based on this case and others he did not describe, Roy claimed that shoplifting is a symptom of "stress" in families of the mentally handicapped. I would disagree with this view, if it is based largely on the presented case, as the father was "severely depressed", being referred for treatment of his depression.

It is well known that a large percentage of women who shoplift are depressed (Gibbens, 1971), with the most frequent diagnosis being depressive neurosis (Bradford & Balmaceda, 1983). Gibbens (1971) claims that shoplifting may be the *earliest* symptom of depression in these women. Additionally, Fishbain (1987) has recently presented case evidence that indicates that the risk-taking of shoplifting may be important to kleptomaniac behaviour. Risk-taking behaviour has been found to have an antidepressant effect in depressed young males (Parker & Brown, 1979). Thus Fishbain (1987) has postulated that in his patient depression served as a stimulus to the kleptomaniac behaviour, which in turn had an antidepressant effect through a symptom relief mechanism (Coid, 1984). I wonder if this same mechanism, rather than "stress", could be a more precise explanation for the father's shoplifting?

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Auditory Hallucinations Due to Ear Disease

SIR: Following the recent correspondence concerning unilateral auditory hallucinations and ear disease (Khan *et al*, *Journal*, February 1988, **152**, 297–298; Gordon, *Journal*, August 1988, **153**, 263–264; McBride and Hamilton-Kirkwood, *Journal*, August 1988, **153**, 264), it is worth noting that complex auditory hallucinations may also complicate bilateral ear disease, since it is under these circumstances that confusion with psychiatric disease is most likely to occur.

Case Report: An 83-year-old widow with longstanding deafness abruptly developed auditory hallucinations, which she recognised as "Harry Lime and His Orchestra" repeatedly playing a medley of songs from her youth, including favourites like "Horsie Keep Your Tail Up" and "Hold Your Hand Out You Naughty Boy". She initially thought the music was coming from an external source, such as neighbours playing a tape, but came to realise it was not real. She heard the music for long periods, and it often woke her from sleep. She had been treated for reactive depression two months earlier after the death of her pet dog, but at the time of her auditory hallucinations she had no psychiatric symptoms. She had a past medical history of atrial fibrillation and mild asymptomatic IgM paraproteinaemia. Neurological examination, including psychometry, was normal apart from moderate (50–60dB) bilateral sensorineural deafness. A CT brain scan showed a small subcortical infarct in the left parietal lobe. Her symptoms were unchanged one year later.

The association between deafness and auditory hallucination has long been recognised (Rhein, 1913); several similar cases have been reported in recent years (Ross *et al*, 1975; Miller and Crosby, 1979; Hammeke *et al*, 1983) and the phenomenon is probably commoner than is generally appreciated (Ross, 1978). It is characterised by the development of repetitive musical hallucinations (usually of familiar tunes with occasional unformed noises) in elderly patients with longstanding bilateral deafness.

The patients are often able to change the music by singing or thinking of a different tune, but cannot suppress it entirely. The hallucinations generally persist unchanged for many years, during which time the patients come to accept their unreal nature. Hallucinations of the spoken word occur only rarely and lack personal reference; neurological and mental state examination is otherwise normal apart from bilateral deafness due to otological disease. As in the unilateral case described by Khan *et al*, treatment with a hearing aid may be worthwhile.

It is likely that auditory hallucinations complicating deafness are a further example of 'release' hallucinosis secondary to sensory deprivation, analogous to visual hallucinations in blindness (Charles Bonnet syndrome) and phantom limb hallucinations following damage to peripheral nerves, although in both the auditory and visual hallucinations an additional central lesion (such as the parietal stroke in this case) may act as a final precipitating factor.

I am grateful to my grandmother for her help in confirming the genuine nature of the music described by this patient.

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Anorexia Nervosa and Infantile Autism

SIR: There are no reports in the literature of children with infantile autism who subsequently developed anorexia nervosa, although Gillberg (1985) has proposed that the two conditions might be related. We should like to report the case of a 16-year-old girl with anorexia nervosa who was previously diagnosed as having infantile autism.

Case Report: The girl was a only child; she was an irritable baby who would not sleep. Her eye contact was poor and she rarely smiled. She did not like being cuddled and failed to seek comfort from her parents. Furthermore, she showed little concern for the feelings of others and failed to form any friendships. Language development was abnormal; she did not use baby talk, and when she did learn to speak, her speech was monotonous, lacking cadence, and delayed echolalia was prominent. She never imitated other people, and did not use gestures when speaking. Her play was stereotyped, unimaginative, and solitary. At the age of four, she was diagnosed as suffering from infantile autism. A WISC test showed her to be of low-average intelligence.

At the age of 12 the girl started to gain weight and she attained the menarche. Other children's teasing prompted her to diet and avoid meals; if she did eat she would vomit afterwards. She tried purgatives at this time, but found them of little help. Apart from a short hospital stay, she was managed as an out-patient until she was 16, when she was admitted because of severe and sustained weight loss. She weighed 38.6 kg (70% of her ideal body weight). She felt that she was fat and wished to continue dieting. She would use all opportunities to dispose of food and was exercising excessively. She also gave a 12-month history of amenorrhoea. She fulfilled the ICD–9 and DSM–III–R criteria for anorexia nervosa.

The autistic child's obsessive desire for maintenance of sameness and the anorectic adolescent's obsessive preoccupation with food and the strict rituals associated with it has led Gillberg (1985) to suggest that the two conditions might be associated. He describes four families in which a boy had infantile autism and a near relative had anorexia nervosa. Apart from a higher than expected incidence of the two conditions occurring in the same family, he was unable to demonstrate any reason for the association. While this case supports Gillberg's hypothesis, it would seem likely that the association is due to chance.

Extreme food fads are well described in autistic children (Rutter, 1985). This case illustrates that anorexia nervosa does occur in adolescents with autism and that it is important that it is diagnosed, so that appropriate treatment can be given.

We would be interested to hear of any other cases in which these two conditions co-existed.

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