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Prion disease in Sri Lanka

Butler (2006) emphasises the importance of psychiatrists being aware of prion disease. We feel that psychiatrists in low- and middle-income countries also need to be aware of these disorders. The low prevalence rate in such countries might be attributable to underdiagnosis and underreporting. Prion diseases are not included in the list of notifiable diseases in countries such as Sri Lanka and even diagnosed cases are not notified.

Butler & Fleming (2001) stated that approximately two-thirds of patients with new-variant Creutzfeldt–Jakob disease (CJD) present with psychiatric symptoms such as anxiety, depression, apathy and withdrawal. Somatic symptoms are a common presentation of depression in countries such as Sri Lanka. Even neurological symptoms such as pain and headache can be features of depression and the diagnosis of prion disease might be easily missed.

Two cases of prion disease have been diagnosed in the psychiatry unit at North Colombo Teaching Hospital over the past 10 years. Both patients were referred for the assessment of depression and later developed neurological symptoms such as myoclonus. Electroencephalography revealed a characteristic pattern of CJD (further details available from the authors). Other patients with CJD who presented with psychiatric symptoms have been reported from different units in Sri Lanka (Gunathilake *et al*, 1998). All these cases appear to be of the sporadic type.

Although CJD is a known cause of dementia, a patient presenting with dementia might not always be investigated for prion diseases because of the perceived low prevalence of the disease in low- and middle-income countries.

Moreover, CJD is a transmissible disease, and a lack of awareness of its true prevalence might lead to a lax attitude regarding precautions against spread. Prion

protein is not destroyed by ordinary sterilisation procedures but requires sophisticated methods of sterilisation which might not be available in low- and middle-income countries. Prion diseases can also be transmitted through meat. Although there are regulations regarding meat production and sale, these are not strictly adhered to in most low- and middle-income countries, so although prion diseases might not be common in these countries, the risk of transmission might be higher. Furthermore, the healthcare systems might be unprepared to meet the challenges of an epidemic. Therefore, it is important to raise awareness of prion diseases among clinicians worldwide.

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‘Major depression’ in Ethiopia: validity is the problem

Mogga *et al* (2006) like the majority of published studies of people from low- and middle-income countries rely exclusively on Western measures of psychopathology (Hollifield *et al*, 2002). Culture is seen as mere packaging and is disregarded while standardised methodologies (‘reliability’) applied to universal psychobiological man get at the ‘real’ problem (Summerfield, 2004). This is a form of imperialism.

‘Reliability’ cannot redeem a study that commits a category error: the assumption that because phenomena can be identified from one setting to another, they mean the same everywhere. African cultures emphatically do not share a Western ethnopsychology that defines ‘emotion’ as a feature of individuals rather than situations, being internal, often biological, involuntary, distinct from cognition, a cause of pathology and targetable by technical interventions (Lutz, 1985). ‘Major depression’ is not a timeless, free-standing, internally coherent,

universally valid, pathological entity requiring medical intervention (Summerfield, 2006).

The hard truth, which if owned would totally disrupt business as usual, is that psychiatric measures are the products of a Western epistemology, including models of mind and definition of personhood. They simply cannot be turned into universally valid instruments – no matter how much tinkering with criteria and translation.

Noting the raised ‘disability’ scores and increased attendance at traditional healers, I do not doubt that something was ailing some of those with ‘persistent depression’. However, it is likely that this was a very heterogeneous group and that undiagnosed physical illness, particularly the diseases of poverty, was a major determinant. The only solution offered was antidepressants and it is no surprise that adherence was poor.

In the last few lines Mogga *et al* state that ‘more information is needed regarding the characteristics, beliefs, knowledge and illness attributes’ of the population. These domains should have been the point of departure of the study, not a mere afterthought. What can emerge when researchers know so little of the lived lives of participants?

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Authors’ reply: We agree that there is inevitably a limitation in the use of measures developed in a different cultural setting. Our measure of depression, the Composite