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Neuroleptic Malignant Syndrome (NMS) and Tardive Dyskinesia

SIR: Haggerty & Gillette (*Journal*, January 1987, **150**, 104–105) seem to have concluded that NMS developed while the patient was having reserpine and lithium. The details they give do not support such a conclusion, as they mention in their discussion. For example, they do not mention any alteration in consciousness after lithium and reserpine were started: besides rigidity, hyperpyrexia and autonomic dysfunction, alteration of consciousness in varying degrees is a *sine qua non* for the diagnosis of NMS (Caroff, 1980). Here, only autonomic dysfunction was noticed after starting lithium and reserpine. Moreover, the progression of NMS is known to be very rapid after onset. In more than 90% of 120 cases reviewed, the full syndrome developed within 48 hours of the first symptoms (Shalev & Munitz, 1986). It is naïve to conclude that mild NMS developed over a period of two weeks and that the full-blown syndrome began later, when thioridazine and haloperidol were started.

What is of interest in this report is the unusually long duration of the NMS episode (seven weeks). Generally, it is presumed that NMS lasts for 5–10 days after discontinuation of oral neuroleptics (Sternberg, 1986). I have come across another patient in whom the syndrome persisted for three weeks after cessation of haloperidol and remitted after a 17-day course of amantidine (Woo *et al*, 1986). Treatment was continued for a further period of five months. Such an abnormally long duration may have something to do with the patient's metabolic characteristics, as differences in absorption and first pass metabolism are known to cause wide inter-individual variations in the plasma levels of neuroleptics.

Moreover, neuroleptics, being highly lipophilic, can be detected for weeks after discontinuation.

Caution is required before concluding that unexplained fever is due to NMS. This is clear when one considers the authors' suggestion that reports by family of transient diaphoresis and elevations of temperature in the months prior to admission were probably because of NMS in "milder form". In the absence of any alteration of consciousness such an interpretation is not justified. At the moment, there is not enough clinical data to justify the spectrum concept of neuroleptic toxicity (Corlon, 1986) which the authors seem to have in mind.

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Continuum of Psychosis and the Gene

SIR: Crow's theory (*Journal*, October 1986, **149**, 419–425) bears a striking similarity to the theory of Britain's best-known psychologist, Hans Eysenck, to the effect that a heritable trait of psychoticism (*P*) underlies much psychotic (and indeed psychopathic) disturbance (Eysenck & Eysenck, 1976, 1985). Like Crow's continuum, Eysenck's *P* has sometimes been considered to be related to cerebral lateralisation of function (Brand, 1981) and to forms of creativity and achievement (Claridge, 1985) that might explain the persistence of high-*P* genes in the population despite the lowered average fertility of people who suffer outright psychotic disturbance.

I wonder, could the theories of Crow and Eysenck by any chance be related?

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Koro-Like States

SIR: We have under our care a 25-year-old male patient with complaints of penis and testicles shrinking into his abdomen.

Case report: This man, from a working-class English background, initially presented in 1983 at the age of 21, with an anxiety state and reactive depression for which he was admitted to hospital for further assessment. He had had both psychic and somatic anxiety symptoms. At that stage there was no evidence of a major affective or schizophrenic illness. Like the patient described by Modai *et al* (*Journal*, October 1986, 149, 503–506), this young man was physically well-built but emotionally immature. He presented a poor self-image and usually responded to any threat to his ego by being verbally aggressive. His parents' marriage broke up when he was nine. He was left with his father, whom he always perceived as being a domineering man. He could not forgive his mother for leaving him and still harbours a strong feeling of rejection. He had a history of faecal soiling and repeated hospital admissions for successive eye-operations (following an accidental injury) around the age of ten. He first complained of his penis and testicles retracting into his abdomen while in hospital in 1983, coincidental with the break-up of his first serious relationship with a girlfriend. His mood subsequently deteriorated. He was treated with amitriptyline (50 mg/day) and stelazine (15 mg/day). The depression improved, but his belief about his genitalia remained unaltered. He was re-admitted a year later, and again in 1986, with clear-cut episodes of hypomania. His hypomania has now remitted, but during both these admissions he maintained his belief about his retracting genitalia. His concern is such that he avoids places where his genitalia may be exposed and he despairs of ever having a girlfriend again.

In contrast to classical koro, there does not appear to be a cultural factor in this case. Although koro is rare in the Western hemisphere, koro-like states may not be uncommon and may be under-reported.

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HIV and the Psychiatric Hospital

SIR: Most readers are aware of the controversy concerning the treatment of patients infected with the human immunodeficiency virus (HIV) presenting with various medical problems. There has been little discussion of the problems encountered when psychiatric disorder arises in these patients. Colleagues in virology and venereology assure us that the transmissibility of HIV by any route other than by sexual contact or transfusion is small. We may therefore rest assured that the aggressive self-mutilating or spitting patient presents little risk to staff or other patients provided that proper precautions are taken. I have been assured that needlestick injuries are ineffective in transmitting HIV, although I would still like to see some evidence of this, given the frequent need to sedate acutely psychotic and resistive patients by intramuscular injection.

The major problem in dealing with HIV-positive patients lies elsewhere, and has moral and practical dimensions. It is not uncommon for psychiatrically ill patients to be in a state of sexual hyperarousal, most often seen in mania. Equally, most long-stay facilities have a significant sexual sub-culture where intercourse is traded e.g. for the price of a few cigarettes. While staff try to prevent such activities, it is impossible to achieve 100% success. Introduction of HIV carriers to a psychiatric unit therefore poses the threat of transmission to patients whose judgement is impaired by virtue of mental illness.

Morally, detention of a patient under a section of the Mental Health Act implies a responsibility to guard that patient against the consequences of his or her impaired judgement. The sheer terror induced by being diagnosed as HIV positive, plus the profile of *some* high risk groups (promiscuous homosexuals and drug addicts), suggests that as the HIV epidemic continues, psychiatric hospitals will have a higher prevalence of HIV carriers than the population at large. Furthermore, HIV-associated dementia will probably require psychiatric placement, again increasing the prevalence. The moral question I would ask is: 'How can we defend detaining a patient who is at risk to his or herself by virtue of mental illness and whose condition entails a tendency to sexual promiscuity, in a facility where the prevalence of HIV carriers may be above that in the community?'

Practical problems abound. Closer supervision through augmented staff levels could, in theory, preclude the possibility of intercourse in hospital. If a middle line is taken and only those who are HIV positive are "specialed", we run into the problem of consent for screening. Also, it is a criminal offence to disclose the HIV status of a patient to unauthorised people (not the case with Australia Antigen).