References

BRYCE-SMITH, D. & SIMPSON, R. I. D. (1984) Anorexia, depression and zinc deficiency. *Lancet*, **ii**, 1162.

COUSINS, R. J. (1986) Zinc metabolism – co-ordinate regulation as related to cellular function. *Proceedings of the XIII International Congress on Nutrition*, pp. 500–504. London: John Libbey.

MEADOWS, N. J., RUSE, W., SMITH, M. F., *et al* (1981) Zinc and small babies. *Lancet*, **ii**, 1135–1136.

MINISTRY OF AGRICULTURE, FISHERIES AND FOOD (1981) Survey of copper and zinc in food. *Food Surveillance Paper No 5*. London: HMSO.

SNAITH, R. P., CONSTANTOPOULOS, A. A., JARDINE, M. Y., *et al* (1978) A clinical scale for the self assessment of irritability; to be known as the Irritability, Depression, Anxiety (IDA) Scale. *British Journal of Psychiatry*, **132**, 164–171.

Musical hallucinations

SIR: Fenton & McRae (*Journal*, September 1989, **155**, 401–403) report the case of musical hallucinations in a deaf elderly woman. I would like to report a similar case.

Case Report:

A 74-year-old widow, living alone, was admitted as an emergency to the acute Psychiatric Unit of the District General Hospital after she had become acutely disturbed. She left her taps on, had broken most of her crockery and was banging on the walls claiming that she was being tormented by hallucinatory voices. All routine investigations were normal, including physical and neurological examinations, full blood count, ESR liver function tests, B12 thyroid screen, chest, skull X-ray, and EEG. Behaviour improved following treatment with trifluoperazine (3 mg t.d.s.). She continued, however, to complain of an insistent hallucinatory voice emanating from her vagina – in the form of songs being repeated over and over again, the main ones being 'The Old Rugged Cross', 'Jerusalem', and 'The Hallelujah Chorus'. She was not able to dismiss these hallucinations, and attempts at increasing medication did not bring them under control. The patient was often noted to sing along with the voices; at other times they appeared to irritate her.

Six years before this admission she had begun to complain of vaginal pain. Over the years she was investigated intensively, receiving consultations with a gynaecologist, orthopaedic surgeon, physician, psychologist, and the pain clinic. Apart from some mild atropic vaginitis, no treatable pathology could be found. She was noted to be becoming increasingly deaf, and acquired a hearing aid.

After intensive investigation she was referred to the psychiatry department, the diagnosis then being psychogenic pain, possibly secondary to atypical depression. By this time she had already been on a large number of analgesics and a number of antidepressants, none of which had helped.

She was independent and socially active, having had no previous psychiatric disturbance. She had been married for 44 years, her husband dying suddenly of a cardiovascular arrest 10 years before the admission. Four years after his death she had become involved in a sexual relationship with a man 30 years younger than herself. She felt unhappy and guilty about this relationship, but was unable to end it. The psychologist felt that the development of the pain was an attempt to bring the unsatisfactory relationship to an end. However, despite the fact that the relationship ended, the pain persisted.

She later admitted that she had been hearing the hallucinations from her vagina the whole time, but had changed the symptom into a pain because she felt intensely embarrassed.

This case is interesting in that it outlines several of the features mentioned by Drs Fenton & McRae: the patient had long-standing deafness, and had embarked on a relationship with another man much younger than herself late in life. The patient was reluctant to report her symptom because of the fear that she would be deemed mad. Although major tranquillisers alleviated the symptom, the problem did not resolve entirely. Detailed psychometric testing was not performed, but there was no evidence of cognitive impairment at the time of presentation, nor on subsequent follow-up.

I. MCLOUGHLIN

The Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne NE1 4LP

A HUNDRED YEARS AGO

Hypochondria and hysteria in men and women

Paget and other authorities have pointed out that hypochondria is much commoner in men than in women. Some physicians are too ready to believe that this aphorism implies a precise homology between hysteria and hypochondria, the former being, so to speak, the form which the latter assumes in woman. Yet few can deny that men are sometimes attacked with a disease bearing all the general symptoms of hysteria. A man may have hysterical fits, or may show chronic hysteria, becoming bedridden or fancying that a joint is stiff or inflamed. German and Russian authorities have discovered that true hysteria in man is frequent, not in over-civilised countries but among semi-civilised nations, such as the Circassians and Persians. Dr Mendel has recently written a paper in the *Deutsche med. Wochenschrift* on Hypochondria in the Female Sex. He maintains its distinction from hysteria. He distinguishes three