

environment, and take up valuable nursing time that could be used to treat patients with demonstrable psychiatric illnesses, needing care which could only be provided by a hospital.

These are perhaps extrapolations from the data. If there is direct empirical evidence that lives are saved by short term hospitalization, then that would supersede other considerations.

D. PETER BIRKETT

11 North Airmont Road,
Suffern, New York 10901, USA

Lorazepam Dependence and Chronic Psychosis

DEAR SIR,

Over the past few years there have been increasingly frequent reports of both psychological and physical dependence on the benzodiazepines (Tyrer *et al.*, 1981) and of transient paranoid psychotic symptoms or depression occurring during withdrawal (Ashton, 1984; Olajide & Lader, 1984). We report here a case of lorazepam (Ativan) dependence which was unusual in that it mimicked a chronic schizophrenic illness.

A single man aged 28 was admitted with a history of increasingly withdrawn bizarre behaviour over seven years. He had an uneventful childhood, performing well at school. At the age of 19, in his first year at technical college, he became socially anxious, his academic performance declined and he gave up his studies and stopped going out. His general practitioner prescribed lorazepam 1–2 mg daily, and during the next few years he took the drug in rapidly increasing amounts, reaching and continuing on 20–30 mg daily. He became increasingly withdrawn, solitary and apathetic, spending most of the five years before admission in his locked and filthy bedroom with the blinds permanently drawn, refusing to eat with his family. He often threatened his general practitioner with violence if she did not prescribe the drug, and was aggressive to his parents. In the year before admission he said that the neighbours were plotting to harm him, and often was heard talking to himself as if answering voices. He had been seen three times over the years by psychiatrists but had always refused to come into hospital and his parents finally agreed to compulsory admission. Latterly he had been taking occasional aspirin and codeine tablets for toothache but there was no evidence of abuse of any other drugs or alcohol.

On admission he was extremely dirty and dishevelled with very long hair and finger nails. He was detached, preoccupied and slightly perplexed,

avoiding all eye contact. There was no clouding of consciousness, nystagmus or dysarthria. He spoke little, but expressed the belief that the ward was bugged with television cameras. He was treated with haloperidol 9 mg daily and diazepam in an initial dosage of 40 mg daily reducing gradually over ten days. The haloperidol was discontinued after two weeks due to severe extrapyramidal side effects. The next day there was a dramatic improvement in his mental state with recovery of insight, complete disappearance of the psychotic symptoms and emergence of a personality which was warm and friendly. Six months have now elapsed and he has remained moderately anxious without a craving for lorazepam but no evidence whatever of personality deterioration. The insidious and steady deterioration in personality and social functioning over seven years, latterly with overt psychotic ideation, strongly suggested a diagnosis of chronic schizophrenia. The lorazepam dependence seemed secondary. The rapid resolution of symptoms after withdrawal of lorazepam suggested that the drug was the main cause of the 'defect state'. Although transient psychotic symptoms occurring with lorazepam withdrawal are well recognised, long-standing psychotic behaviour during the time of abuse is not. Benzodiazepine dependence should be considered in the differential diagnosis of chronic as well as acute psychotic states.

A. A. FRASER
I. M. INGRAM

Southern General Hospital,
Glasgow G51 4TF

References

- TYRER, P., RUTHERFORD, D. & HUGGETT, T. (1981) Benzodiazepine withdrawal symptoms and propranolol. *Lancet*, *i*, 520–522.
 ASHTON, H. (1984) Benzodiazepine dependence: an unfinished story. *British Medical Journal*, *288*, 1135–1140.
 OLAJIDE, D. & LADER, M. (1984) Depression following withdrawal from long-term benzodiazepine use: a report of four cases. *Psychological Medicine*, *14*, 937–940.

Dupuytren's Disease and Mental Handicap

DEAR SIR,

Just over 150 years ago (1933), Baron Dupuytren's letter on 'Permanent retraction of the fingers produced by an affection of the palmar fascia', was published in the *Lancet* (1834) and the condition now bears his name. An extensive literature has since appeared concerning its aetiology, pathogenesis and treatment. Many possible causes or concomitants of Dupuytren's disease were reported, e.g. heredity, trauma,

epilepsy, Peyronie's disease, diabetes, injury, liver disease and others (Nohle *et al*, 1984). None have been universally accepted or proved.

When studying the increased incidence of longevity of the mentally handicapped, we noted a number of cases of Dupuytren's disease. We therefore decided to survey the total population of the Stoke Park Group of Hospitals in Bristol, resident in January 1984. There were 1092 mentally handicapped patients (576 males and 516 females). Out of the total number, 36 suffered from Dupuytren's disease (22 males and 14 females). All detected cases were independently assessed by hospital medical staff, visiting orthopaedic surgeon and hospital physiotherapists. Age ranged from 31 to 77 (mean 53.3 years) in males and from 32 to 96 (mean 69.1 years) in females. IQ distribution was from <15 to 69 (mean 33.1) in males and from <15 to 69 (mean 40) in females. Distribution of Dupuytren's disease was as follows:

Males

Both hands	11 cases
Both hands and both feet	2 cases
Right hand only	5 cases
Right hand and left foot	1 case
Left hand only	2 cases
Right foot only	1 case
	<hr/>
Total:	22 cases

Females

Both hands	8 cases
Both hands and right foot	1 case
Both feet	1 case
Right hand only	4 cases
	<hr/>
Total:	14 cases

Epilepsy was present in nine males and seven females. Two males suffered from Fragile X Chromosome abnormalities and one female from diabetes. No Down's syndrome cases suffered from Dupuytren's Disease, nor were any other abnormalities detected so far, but we are continuing a detailed examination and we shall report our findings at a later date.

J. JANCAR
H. E. D. GRIFFITHS
BARBARA SAWDON

Stoke Park Hospital,
Stapleton, Bristol BS16 1QU

References

- DUPUYTREN, B. (1934) Permanent retraction of the fingers produced by an affection of the palmar fascia. *Lancet*, ii, 222–225.
- NOBLE, J., HEATHCOTE, J. C. & COHEN, R. (1984) Diabetes mellitus in the aetiology of Dupuytren's disease. *Journal of Bone and Joint Surgery*, 66B, 322–325.
- CARTER, G. & JANCAR, J. (1983) Mortality in the mentally handicapped: A 50 year survey at the Stoke Park Group of Hospitals (1930–1980). *Journal of Mental Deficiency Research*, 27, 143–156.

Season of Birth of Schizophrenics in Hong Kong

DEAR SIR,

In his article entitled "A Re-Evaluation of the Viral Hypothesis" (*Journal*, September 1984, 145, 243–253), Dr. T. J. Crow opined that the season of birth effect is accentuated in, and perhaps confined to the group of patients without a family history of the disease.

Other workers, however, found that this effect appeared among unmarried (presumably severe) schizophrenics but not among married patients (Watson *et al*, 1984) and schizophrenics with negative syndromes are significantly more often born in the winter (Opler *et al*, 1984).

To clarify the situation, I collected all schizophrenic cases that came to me for follow-up within a period. Cases are divided into those with and without family history and their dates of birth are recorded. For those with family history in their first degree relatives (parents and siblings), only those whose relatives are suffering from schizophrenia are included, while those suffering from affective disorder or neurosis are discarded. Altogether I collected 188 cases, of these 122 have negative family history and 66 have positive family history.

As Hong Kong is a subtropical city, there are only two distinct seasons; the hot months range from April to September and the cool months from October to March. Nevertheless, outdoor activities are practised all the year round without any restrictions as in temperate countries. Moreover, infectious diseases are more common in summer months than in winter months.

My findings are (statistical method by analysis of variance):

1. There is no reason of birth effect in the schizophrenic patients without family history (P:NS).

2. There is significant season of birth effect in the schizophrenic patients with family history. More births are seen in the cool months, that is, October to March (P<0.005). There is no sex difference.

There is indication that schizophrenic patients with positive family history have a poorer