Psychotropic drugs were first implicated with the syndrome of inappropriate secretion of anti-diuretic hormone (SIADH) by Luzecky *et al* (1974) in a patient receiving amitriptyline. This has been noted on six subsequent occasions with this drug, and further reports of SIADH in patients receiving imipramine (2 reports), desipramine (3 reports), carbamazepine, clomipramine, nomifensine, dothiepin, and tranylcypromine have been published.

*Case Report:* This patient was admitted after a two-month history of manic-depressive psychosis – depressed type. She had been treated with amitriptyline (50 mg b.d.). There was a history of three previous episodes of depression which had responded to antidepressant medication or ECT.

On admission her sodium was 139 mEq/l. She was also noted to be anaemic, this being attributed to long-term therapy with ibuprofen. Her medication was changed to lofepramine (rising to 210 mg/day). No change was made to her other medication: atenolol (100 mg mane), lormetazepam (1 mg nocte), and ispaghula husk (Fybogel). Fifty days after starting on lofepramine the patient was noted to be becoming anorexic, weaker, and confused. Her sodium was noted to have dropped to 121 mEq/l. The serum osmolality dropped to 250 mOsm/kg (normal range 275–295), and the urine osmolality rose to 519. There was no evidence of intoxication. Physical examination was unremarkable. Chest X-ray and midstream specimen of urine was normal.

Fluids were restricted to 1 l/day, the lofepramine stopped, and trazodone commenced. Eventually the sodium returned to normal values (139 mEq/l), and the serum osmolality rose to 276 mOsm/kg. She later went on to respond well to a short course of ECT.

We feel that this patient fulfilled the criteria for a diagnosis of SIADH according to the criteria of Bartter & Schwartz (1967). She had hypo-tonicity of the serum, with a low sodium level and inappropriately elevated urine osmolality. The urine sodium and arginine-vasopressin were not measured. There was no clinical or biochemical evidence of cardiovascular, liver, renal, or adrenal disease, nor of dehydration. There was no report of recent head injury. Re-exposure of the patient to lofepramine was not done on the grounds of the patient's poor clinical condition. Hyponatraemia may occur acutely in psychiatric patients due to the psychosis itself (Rasking *et al*, 1975), secondary to compulsive water drinking (Chinn, 1974), or as a result of psychotropic medication.

The Committee on Safety of Medicines have received four reports of antidiuretic disorders possibly related to lofepramine. The manufacturers, E. Merck Limited (pers. comm.), have received two reports of hyponatraemia in patients receiving lofepramine. The first published report describing the possible association was by O'Sullivan & Oyebode (1987).

The effect noted is probably drug-specific to the patient and not to the drug class, as most reports show patients unaffected when treated with an alternative drug either before or after the implicated drug.

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## Munchausen Syndrome Masquerading as AIDS-induced Depression

SIR: The psychiatric disorders associated with AIDS have been well documented (Fenton, 1987), and cover the breadth of psychiatric nosology. We describe a case of the Munchausen syndrome presenting with the fallacious claim that the patient had AIDS. To our knowledge this particular psychiatric association has not been previously reported.

*Case Report:* A 32-year-old unemployed seaman presented to the casualty department complaining of depressed mood, early morning waking, poor appetite, loss of concentration, weight loss, and a voice telling him to kill himself. He said these symptoms had begun when, a few months earlier, he had contracted pneumocystis carinae pneumonia and been informed that he was HIV positive as a result of his long-term intravenous drug abuse.

He was admitted to a psychiatric ward and gave a similar history, but with some differences in the timing of events. Suspicion was aroused when it was discovered that he was not known at the address he had given nor at hospitals to which he claimed to have been admitted. The hospital at which he claimed to have been diagnosed HIV positive refused to give any information as a matter of policy. The GP he had quoted had retired a year earlier and was untraceable.

The patient had a number of tattoos, and was eventually identified with the help of a merchant shipping company

who kept records of employees' distinguishing marks. With this information it was ascertained that the patient had a criminal record and had been admitted to many hospitals using at least five aliases, usually presenting with haemoptysis, both in this country and abroad. He had recently been deported from Holland.

He was finally persuaded to have an HIV test. It proved negative, and the patient was confronted; he admitted using a false name (the name of a Liverpool footballer), and agreed to give his real name, giving the name of another Liverpool footballer. He was discharged.

Throughout his admission the patient was treated cautiously, in case he did have AIDS or a psychiatric condition causing him to believe he had AIDS (Miller *et al*, 1985). This case, we believe, represents a particularly difficult and disruptive variant of Munchausen syndrome, because AIDS induces great anxiety in the staff involved with the patient's care and requires the institution of recommended precautionary measures (Fenton, 1987). In view of the special attention to the patient and the sympathetic approach required, one might expect AIDS to appeal to Munchausen patients. In this case, a fairly typical example of the syndrome, the disruption caused was maximised by our particular difficulty in finding any information about the patient. This surely adds further weight to the argument for a centralised register of Munchausen patients to allow earlier detection (Jones & Horrocks, 1987).

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## Corrigenda

*Journal*, December 1988, **153**, 850 (R. J. Russell). On the fifth line, "current" should read "voltage".

*Journal*, September 1988, **153**, 355 (R. Manchanda *et al*). On the third line, ". . . patient (see Fig. 1, patient 1)" should read ". . . patient (their patient 1)".

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