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Correspondence

LATE PARAPHRENIA

DEAR SIR,

The paper by Dr P. S. Grahame on 'Schizophrenia in Old Age (Late Paraphrenia)' (*Journal,* November 1984, **145,** 493–495) reports an unusually high proportion of patients with first rank symptoms in this condition (14 out of 25). This is not only at variance with results reported by Post (1966) but also with the strong clinical impressions of people working in the field of old age psychiatry. Kraepelin (1919) in the later editions of his textbook stated that only about 40% of his patients whose illness was diagnosed as paraphrenia progressed to dementia praecox of the paranoid type. Post nearly half a century later found that ⅓ of his series were diagnosed as suffering from schizophrenia and had first rank symptoms.

Dr Grahame's suggestion that the higher incidence of first rank symptoms in his sample might be related to the use of the Geriatric Mental State Schedule (GMS) in his own study is not altogether convincing. This schedule is not particularly loaded with questions relating to first rank symptoms and if anything gives much greater weight to the detection of cognitive impairment and the presence of depressive symptoms (Gurland *et al,* 1976). Furthermore a larger unselected series of cases of late paraphrenia collected at the Maudsley Hospital as part of a study on the possible role of organic factors in the genesis of this syndrome also employed the GMS and yielded a smaller proportion of patients showing first rank symptoms (16 out of 43).

We cannot help wondering whether some other factors possibly related to patient selection may have been operating in Dr Grahame's series. As no information is provided about patients' cognitive function it is difficult to know whether the author's statement that those included had to have "the absence of dementia" may mean that patients with minor cognitive impairment of a non-progressive nature were excluded. Although we wholeheartedly agree with the author's suggestion that the age limits in DSM III should be reviewed we consider that his bold statement that his study "confirms that late paraphrenia is one of the schizophrenias" is unsubstantiated by the data provided.

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References

GURLAND, B. J. *et al* (1976) A semi-structured clinical interview for the assessment of diagnosis and mental state in the elderly: The Geriatric Mental State Schedule. *Psychological Medicine,* **6,** 451–459.

KRAEPELIN, E. (1919) *Textbook of Psychiatry.* Vol. III, Part 2. (Translated by R. Mary Barclay from the 8th German edition) Section on endogenous dementias (ed. George M. Robertson). Edinburgh: E & S Livingstone.

POST, F. (1966) Persistent Persecutory States of the Elderly. Oxford: Pergamon.

Dr Grahame replies

DEAR SIR,

Professor Levy and Dr Neguib take issue with my unusually high proportion of patients with first rank symptoms. They quote Kraepelin, Post, and "the strong clinical impressions of people working in the field of old age psychiatry." They further dispute my contention that the GMS has an inherent bias towards identifying first rank symptoms and wonder whether patients with minor cognitive impairment of a non-progressive nature were excluded. In answer I make the following points:

1. There seems to be an assumption that the presence of first rank symptoms is pathognomonic of schizophrenia. I think it is generally well known that first rank symptoms occur in other categories of mental disorder.
2. In 1921, Mayer, a co-worker of Kraepelin's, published a follow up of Kraepelin's original 78 paraphrenic patients and found that more than half had developed typical schizophrenia (quoted by Slater and Roth in *Clinical Psychiatry,* 1969). This finding was in part responsible for the concept of paraphrenia being abandoned.
3. There is no doubt that the GMS asks leading questions relating to first rank symptoms, at variance with Post's methods which avoided leading questions (personal communication), and may thus reasonably be expected to report a higher incidence of such symptoms.
4. As far as was possible I excluded patients with cognitive impairment but it is possible that I may have missed some patients with minor degrees of non-progressive impairment.
5. I am aware of the clinical impression prevailing among psychogeriatricians but impressions can never be as accurate as definite research.

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