

This case emphasises some of the problems with regard to the nosological status of Capgras' syndrome in the cognitively impaired. There may be a spectrum of disorders of recognition. In our case there was no suggestion that the patient believed her husband was an imposter or that he had been maliciously replaced. Our case is similar to those described by Pick (1903) in introducing the concept of reduplicative paramnesia. While resisting a psychoanalytical interpretation, and in the absence of evidence of focal brain lesions (Lewis, 1987), the sequence of events in the genesis of our patient's belief might be as follows: the couple are reunited after a separation but because of a combination of poor visual memory and failure of facial recognition the wife does not recognise her partner's face. However, a sense of familiarity is retained because of other cues, e.g. mannerisms, and has to be explained. The patient's interpretation of events may then take one of two paths: either a confabulation involving a 'duplication' of the same person experienced at two different points in time (or in two different settings as with Pick's cases), or a delusional elaboration that the original partner has been replaced by an imposter. This latter is the classic Capgras' syndrome and may arise more readily in patients with pre-morbid paranoid traits (Burns, 1986). The status of such phenomena in the cognitively impaired may have implications for treatment and requires further elucidation.

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#### ECT in the Elderly

SIR: The report by O'Shea *et al* (*Journal*, February 1987, **150**, 255–257) of cognitive improvement in a very elderly depressed patient treated with ECT is useful in that it reminds us that elderly people should not be denied an effective treatment solely on the grounds of age.

Clinical features which predict a good response to ECT in younger patients also predict a good response to ECT in the elderly (Fraser & Glass, 1980), and the

presence of co-existing dementia does not adversely affect the efficacy and safety of ECT (Weiner, 1982). Age alone is not a contra-indication to the use of ECT (Benbow, 1985).

The clinical details quoted by O'Shea *et al* give little support to a diagnosis of dementia in their 91-year-old patient. She had previously responded to dothiepin, and the episode which led to the use of ECT seems to have been of less than 12 months duration. Her cognitive function was impaired as tested by the Mini-Mental State at a time when she had a frankly psychotic depressive illness, and improved as she recovered in response to treatment. This is not surprising. Fraser and Glass (1980) studied 29 elderly patients (aged 64–86 years) treated with ECT and found that they all had impaired memory function before treatment. Three weeks after ECT all scores had reached levels acceptable as normal. The clinical experience of many psychogeriatricians bears this out.

One problem is that the literature regarding the use of ECT in the very elderly is limited. In a study of 122 patients treated with ECT by the psychogeriatric service at the University Hospital of South Manchester only 16 were aged over 80 years and the oldest was a woman of 88 years (Benbow, 1987).

It is important that ECT is made available to elderly people with depressive illnesses, where the clinical features suggest a likely response and anti-depressant drugs have not been successful or cannot be tolerated. Babigian & Guttmacher (1984) demonstrated a substantially decreased mortality risk in women over 75 years of age treated with ECT in comparison with a non-ECT group. Perhaps age could be regarded as an indication for ECT, rather than the reverse?

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