(Morris *et al*, 1987; Sahakian *et al*, 1987) we found that patients with relatively early Alzheimer disease only reacted as rapidly as controls when an immediate response was required (i.e. with a zero second delay). The data show that when the test stimulus is delayed the Alzheimer patients respond a good deal more slowly than the age-matched controls, and that in this respect they perform far worse than recently diagnosed patients with Parkinson's disease who showed much smaller differences from their own controls on this task.

We suggest that psychomotor speed is a complex variable, and that contrary to belief it is not a useful way of differentiating between cortical and subcortical dementia.

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Dementia in Parkinson's Disease

SIR: Oyebode *et al* (*Journal*, December 1986, **149**, 720–725) present data about dementia in 43 patients with Parkinson's disease, and draw conclusions concerning the prevalence of this. Their population was drawn from patients attending an illustrious neurological centre. Perhaps the area served contains patients with Parkinson's disease who were not referred to the centre, but were looked after by general practitioners, geriatricians, or psychiatrists. There might have been a tendency to fail to refer the bedridden, the incontinent, and the demented.

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Anorexia Nervosa or Dysmorphophobia?

SIR: An alternative diagnostic formulation is possible (*Journal*, December 1986, **149**, 780–782). As Hay (1970) points out, dysmorphophobia is a non-specific symptom often indicative of a 'sensitive personality development', or occasionally early schizophrenia. The phenomenological distinction between the overvalued idea and the delusion depends in part on external evidence of physical abnormality and adverse environmental experience, often in the form of teasing in childhood. This girl was clearly obese at the age of 12, was instructed to lose weight by two professionals, and had previously been teased by family members. The positive family history of a transient psychotic episode in her brother with no further deterioration would support the formulation of a constitutionally-based sensitive personality prone to neurotic elaboration. While the patient meets the criteria for both agoraphobia and social phobia, she apparently never lost enough weight or persisted long enough in her dieting to qualify as a case of anorexia nervosa by DSM–III criteria, but would be more appropriately labelled as having atypical eating disorder.

These diagnostic distinctions may have significant clinical relevance for treatment. Slade and others have documented the variability in body size estimations of anorexics who, as a group, have a tendency to over-estimate certain body part dimensions. Unfortunately, no body image measurements are reported in this case. In contrast, body image measurements have been described in dysmorphophobic patients which might help differentiate them from the anorexic group. Jerome (1980) described a group of patients with dysmorphophobia requesting cosmetic rhinoplasty who were *more* accurate than normal controls in estimating their own nose size, and spent more time looking at this particular feature of their appearance in mirrors. The data suggested that dysmorphophobics may be utilising a 'perceptual defence' of over-focusing on specific aspects of their body image. This contrasts with the clinical findings in anorexia nervosa, which suggest an avoidance of observation of their own bodies with parallel mirror avoidance and a relative over-estimation of specific body parts in comparison with controls. Furthermore, a recent article by Norris (1984) suggests that

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