adult population (aged 55–75 years) studied. We have prospectively studied 45 stroke patients (aged 26 to 65 years) for psychiatric morbidity. The most common disorder was depression (in 78% of the patients), followed by generalised disorder (in 17%). Younger age, physical disability (resulting in occupational and social dysfunction) and past history of stroke were strongly correlated with depression. Vascular disease has been found to be associated with a more prolonged duration of depression (Hickie & Scott, 1998), but in our sample 52% of the patients with depression recovered within 3–6 months of treatment. However, two patients who were unemployed when they were disabled by stroke did have depression of prolonged duration. Uncontrolled hypertension (moderate to severe) was associated with the presence of generalised anxiety disorder. The role of medication (especially beta-blockers, calcium channel blockers and sedatives) in producing depression is an important variable and could not be ruled out in six patients. Although laterality of brain lesion (i.e. left hemispheric lesion) and risk of depression have been reported (Robinson & Price, 1982), the subject remains controversial and we did not find any such association. A detailed prospective study on a larger sample of patients from all age groups and different socio-demographic backgrounds is needed to establish the association of depression with various demographic and vascular risk factors for stroke.

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Somatoform disorders: a topic for education

Bass *et al* (2001) believe that somatoform disorders are ignored by psychiatrists and health service planners because of the nature of diagnostic practice, a current preoccupation with only "serious mental illness", limited experience of patients with medically unexplained symptoms in general hospital settings, and stigma. They do not mention whether they have found an increasing fear of litigation to be another contributing factor. Currently, it appears to play a part in delaying referral to psychological services while the patient is exhaustively investigated for any physical pathology. Any comment they might make regarding this practice would be of interest.

Certainly, as they mention, a lack of training of non-psychiatric practitioners in this area contributes greatly to non-referral within the general hospital setting. We would, however, dispute their comment that psychiatrists working in this area find that patients with somatoform disorders "comprise between one-third and one-half of all referrals to the liaison psychiatry service". A review carried out several years ago of the nature of referrals to the consultation–liaison services of two general hospitals in Dublin City (Cullivan *et al*, 1997) suggests a much smaller number of such referrals. Over a 6-month period 491 patients were referred and patients with diagnoses falling into categories F40–F48 of ICD–10 (neurotic, stress-related and somatoform disorders) accounted for only 12% of referrals in one hospital and 15% in the other. As a significant number of the patients in these categories were suffering from adjustment disorders, the numbers diagnosed with somatoform disorders, formed an even smaller percentage of all referrals.

It is worth noting that these were the diagnostic categories provided by the psychiatrists who assessed these patients. The reason for the referrals given by the medical/surgical teams was "no organic cause for symptoms found" in just 1.7% of cases in one hospital and 10.2% in the other. Perhaps somatoform disorders are even more neglected than previously thought? Education of both psychiatric and non-psychiatric personnel regarding these disorders would appear to be in need of urgent review.

Bass, C., Peveler, R. & House, A. (2001) Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *British Journal of Psychiatry*, **179**, 11–14.

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We read with interest Bass *et al*'s (2001) review on somatoform disorders. Although the authors usefully pointed out that these disorders are common and cause severe disability, we were dismayed to find that, ironically, they neglected to mention one of the more common somatoform disorders: body dysmorphic disorder (BDD; also known as dysmorphophobia). A distressing or impairing preoccupation with an imagined or slight defect in appearance, BDD has reported rates in the community of 0.7–2.3% (Phillips, 2001). People with this disorder commonly present to psychiatrists, dermatologists, cosmetic surgeons and other physicians (Phillips & Castle, 2001).

Body dysmorphic disorder causes severe distress and marked impairment in functioning (Veale *et al*, 1996; Phillips, 2001). A high proportion of patients require hospitalisation, become housebound and/or attempt suicide. Completed suicide has been reported in both psychiatric and dermatology settings. Mental-health-related quality of life is poorer than that reported for patients with depression, obsessive–compulsive disorder and a variety of physical illnesses, including recent myocardial infarction and type II diabetes.

Like the other somatoform disorders, BDD is often neglected by psychiatrists. The diagnosis is usually missed in mental health settings (Phillips & Castle, 2001). This is unfortunate, because a majority of these patients request and receive non-psychiatric treatments, such as dermatological treatment and surgery, which are usually ineffective. Many patients consult numerous physicians, request extensive work-ups, and pressure dermatologists and surgeons to provide unsuitable and ineffective remedies. Some patients, in desperation, even perform their own surgery. As one dermatologist stated, "The author knows of no more difficult patients to treat than those with body dysmorphic disorder" (Cotterill, 1996).

The good news is that emerging data indicate that a majority of these patients can be successfully treated with selective serotonin reuptake inhibitors or cognitive–behavioural therapy (Phillips, 2001). It is important that psychiatrists and other physicians screen patients for this disorder so that effective treatment can be provided. Body dysmorphic disorder is a severe psychiatric illness that we cannot afford to neglect.

Bass, C., Peveler, R. & House, A. (2001) Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *British Journal of Psychiatry*, **179**, 11–14.

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