

induced agranulocytosis. Many psychotropic drugs are known to be able to produce changes in the white cell count. Tricyclic antidepressants, phenothiazines, and carbamazepine are all recognised as being able to depress the white cell count. Lithium, on the other hand, is associated with a leucocytosis. On the whole these findings are benign, usually incidental results with no clinical manifestations, and reverse on cessation of the drug (Kaplan & Sadock, 1985). Agranulocytosis with the features of opportunistic infection, however, is a more serious condition, commoner in older females and arising 4–6 weeks after initiation of therapy, which in the case of chlorpromazine can carry a mortality of 30% (Kaplan & Sadock, 1985). This condition arises very quickly and appears unpredictable; thus many authorities believe that routine blood counts are unhelpful and that the doctor should rely on the associated symptoms and signs (Kaplan & Sadock, 1985; Gregory & Smeltzer, 1983).

Actual numbers of patients with these drug-related adverse events are extremely difficult to ascertain. The criteria for reporting a finding as a particular reaction are themselves usually idiosyncratic, depending on the physician's expertise, and there are few guidelines provided to standardise such reports. These problems are compounded by a methodology that is essentially anecdotal, with no control groups. Thus comparisons are difficult and often misleading, with doctors being more likely to report events with newer drugs than with older established compounds. Perhaps the most clinically iniquitous practice, however, is that the reports appear to be acted upon in isolation and out of the context of the overall risk-benefit ratio of the particular drug, and it is the overall mortality from exposure to the drug that should be considered.

Combining data from the Office of Population Censuses and Survey for England and Wales for 1982–84 with similar data from the General Register Office for Scotland over the same period, there were 1029 deaths in which tricyclics either alone or in combination were implicated. This compares with 55 in which mianserin either alone or in combination were implicated. Even allowing for the difference in rates of prescription, the overall mortality associated with mianserin is substantially less than with the tricyclics. Considering deaths resulting from antidepressant drug overdoses alone, the differences are especially striking, with mianserin accounting for only 15 such fatalities per million patients compared with 388 per million for the tricyclics and bridged-tricyclics (Leonard, 1986).

Practising geriatric psychiatry in Canada, I am restricted to using toxic and problematical anti-

depressants in the elderly which themselves can produce serious blood dyscrasias. For example, with amitriptyline 83 cases were reported in Britain between 1964 and 1981, with 18 deaths (Clink, 1983).

Therefore, it is far from clear that amendments to the Data Sheets for mianserin will achieve an improvement in the treatment or outcome of depressed patients. Routine blood monitoring is not likely to detect the uncommon event of a blood dyscrasia, and may well confuse the picture further as there are no controlled data with which to compare results of such testing. The likely outcome is that many doctors will be put off using mianserin, especially in patients who are particularly at risk from the tricyclic antidepressants such as the elderly. Ironically, the CSM may be contributing to increasing the risks of treatment.

R. J. ANCILL

*Riverview Hospital
Port Coquitlam
British Columbia
Canada V3C 4J2*

References

- CLINK, H. M. (1983) Mianserin and blood dyscrasias. *British Journal of Clinical Pharmacy*, **15**, 291S–293S.
- CSM UPDATE (1985) Adverse reactions to antidepressants. *British Medical Journal*, **291**, 1638.
- GREGORY, I. & SMELTZER, D. J. (1983) *Psychiatry: Essentials of Clinical Practice* (2nd ed.). Toronto: Little, Brown and Company.
- KAPLAN, H. I. & SADOCK, B. J. (1985) *Modern Synopsis of Comprehensive Textbook of Psychiatry* (4th ed.). Baltimore: Williams and Wilkins.
- LEONARD, B. E. (1986) Toxicity of antidepressants. *The Lancet*, *ii*, 1105.

Psychological Complications Following a Mis-diagnosis of Deafness

SIR: The differential diagnosis between hysteria and organic illness is important and fraught with pitfalls. Emphasis has been placed on ensuring that organic conditions are not mis-diagnosed as hysterical with consequent delay in treatment (Slater, 1965); however, it has also been recognised that protracted physical investigations and delay in psychiatric referral may worsen the prognosis for true hysterical symptoms (Goodyer, 1981).

Hysteria in childhood is uncommon, and is reported as not occurring in children under five years of age (Goodyer, 1981). We report a case of chronic hysterical deafness presenting at the age of two years with delay in the exclusion of any organic pathology until the age of fourteen years.

Case report: A fourteen-year-old boy presented to the adolescent psychiatric unit with a six-month history of increasingly poor peer and family relationships. He displayed a marked speech impediment, and communication was complicated by an apparently variable and selective deafness. Otherwise, physical examination was found to be normal. Although of average intelligence, his educational attainments were assessed as being at the eight-year level, as were his behavioural, emotional, and social abilities.

The history revealed that at the age of two years he was referred to a child psychiatrist with disturbed behaviour. His language was delayed and he appeared not to respond to noises or speech. At ENT referral, examination of the ear drums was normal but hearing tests suggested he was profoundly deaf. The diagnosis was supported by a history of otosclerosis in the immediate maternal family. He was given post-aural aids, and at follow-up there was improvement in his language and behaviour. Repeated audiometry between the ages of two and fourteen confirmed the diagnosis, although the degree of deafness was inconsistent. Doubt about the diagnosis was expressed, but dismissed when response to spoken sounds improved with more powerful hearing aids.

He attended educational establishments for the deaf until at 13 years of age he was integrated into an ordinary high school. Although he has always displayed various behavioural difficulties at home and at school, it was not until at high school that an educational psychologist noticed that the degree of deafness appeared to vary with his psychological state; at times his hearing appeared normal. Auditory evoked brain stem potentials were performed which showed normal hearing in the right ear with only a 40 dB loss in the left ear.

In the six months following the revised diagnosis his behaviour deteriorated dramatically. It has since been revealed that at eighteen months old he witnessed his father severely assault his mother, following which he hid in a cupboard for two days with his hands over his ears. The boy's mother thinks that the deafness dated from that time. Despite having been an in-patient in an adolescent psychiatric unit for five months both he and his family are still finding it difficult to adjust to the change in diagnosis.

This case illustrates the danger of mis-diagnosing

psychological symptoms as being due to organic illness, and shows that when the correct diagnosis is delayed the sequelae can be severe with significant resultant morbidity. Psychological symptoms are commonly found among the deaf population; the rates appear to be 3–10 times higher than for comparable groups of children with normal hearing (Meadow, 1980). Presumably this was one reason why our patient's behaviour was accepted for so many years. The importance of considering deafness in a young child with behaviour disorders or language delay is well documented (Illingworth, 1983; Williams, 1968). We suggest that where there is any doubt as to the validity of the diagnosis of deafness, a diagnosis of hysterical conversion disorder should be considered.

L. A. HEWSON
P. MORRIS

High Royds Hospital, Leeds

References

- GOODYER, I. (1981) Hysterical conversion reactions in childhood. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, **22**, 179–188.
- ILLINGWORTH, R. S. (1983) *The Normal Child*. Edinburgh: Churchill Livingstone.
- MEADOW, K. P. (1980) *Deafness and Child Development*. London: Edward Arnold.
- SLATER, E. (1965) Diagnosis of hysteria. *British Medical Journal*, *i*, 1395–1399.
- WILLIAMS, C. E. (1968) Behaviour disorders in handicapped children. *Developmental Medicine and Child Neurology*, **10**, 736.

CORRIGENDA

- Journal*, January 1987, **150**, 43–48 (M. W. P. Carney *et al.*). The following co-authors names were omitted from the title page: James Edeh, B. K. Toone and C. Thomas.
- Journal*, February 1987, **150**, 161–163 (J. A. O. Besson *et al.*). In Fig. 1 (page 162) the labels "Schizophrenics ($n=6$) without TD" and "Schizophrenics ($n=15$) with TD" should be interchanged.

A HUNDRED YEARS AGO

French Lunatic Asylums

The supervision of French lunatic asylums appears, if recent accounts be true, to be exceedingly lax. It will be remembered that a short time ago a man was released from an asylum, having been forty years previously confined by his relatives in order to secure his wealth. The escape of another man is now reported, who, although sane, was confined for a year in an ill-lit room, bound hand and foot. Such treatment is strictly forbidden by law, and the matron and two keepers of the establishment have been fined, and the medical superintendent condemned to a fortnight's imprisonment. Such regret-

table and scandalous incidents would be impossible if any control were exercised by the authorities; and although our Gallic friends may manage things in general better than we do in England, their most ardent admirers will be compelled to admit that the protection of lunatics and the supervision of asylums do not redound to their credit.

(*The Lancet*, 8 January, 1887, 109.)

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Surrey