correct. Perhaps 'semeiology' (Gr. *semeion*) should be used to mean the knowledge of signs and 'symptomatology' (Gr. *symptoma*) the knowledge of symptoms. A Greek scholar could help out here! The French use the term *séméiologie* as a sort of cover-all term for both signs and symptoms.

Further to the paper by Drs Rogers and Pullen, I would draw attention to the weird sign in a photograph published by Kempf (1920), who was at the time working at St Elizabeths Hospital in Washington, DC. The illustration, Fig. 85 on p. 728, has the caption, "Elimination or castration of eyeball as a defense (*sic*) against eroticism". This photograph showed a man who has apparently pulled his left eyeball out of its socket. Unless the picture is a fake, this illustrated a case of self-inflicted dislocation of the eyeball. One hopes that the eye ultimately went back to where it belonged!

Enucleation of the eyeball, or dislocation, is to be differentiated from extirpation and damage short of removal from the orbit. Three cases of extirpation of the eyeball were drawn from the early literature by Gould & Pyle (1896), and there are no doubt other reported cases and many more which were not.

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References

GOULD, G. M. & PYLE, W. L. (1896) *Anomalies and curiosities of medicine*, p. 735. Philadelphia: W. B. Saunders.
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SIR: Rogers & Pullen's paper (*Journal*, November 1987, **151**, 691–692) reminded me of a patient.

Case-report: A 47-year-old married women with no history of psychiatric illness was referred to us in 1985 from the casualty department of the local county hospital. Early that evening the patient had tried to harm herself with a bread knife. She had tried to gouge both her eyes out and cut her wrist and legs. Fortunately her husband arrived at the scene and prevented her from injuring herself seriously. She had sustained sub-conjunctival haemorrhages to both the eyes and there were lacerations on both her eyelids. On examination of her mental status she was agitated and uncooperative. Her memory and orientation were intact. She had paranoid delusions, auditory hallucinations, and religious preoccupations. She kept repeating "I have to have a knife. I want to die for God. I have to take my eyes out". She refused to explain it. She was commenced on tablet chlopenthixol (25 mg t.i.d.). Her laboratory investigations revealed that she was grossly hypothyroid – free T_4 1.8 pmol/L, TSH 133.2 μU/ml. For this she was prescribed tablet thyroxin (50 μg daily). She made an uneventul recovery and was discharged from our care after four months. She has remained symptom-free.

The patient injured herself while acting on her delusions and had an underlying organic disorder. I agree with Rogers & Pullen that self-mutilation of the eye is not a single clinical entity, and we are told that it is usually associated with psychosis or organic disorders such as epilepsy, encephalitis, and diabetes. Self-inflicted eye injury secondary to delusions is understandable. What could be the possible explanation when it occurs in the context of organic disorder? I suggest that there may be a neurochemical factor involved.

I am grateful to Dr Fred. J. Bareen for giving me permission to report this case.

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Paranoid Psychosis and AIDS

SIR: It is laudable that Thomas & Szabadi (*Journal*, November 1987, **151**, 693–695) have drawn attention to the possibility of an unusual presentation (paranoid psychosis) in a disease of enormous medical and social concern (AIDS). However, to my mind the case remains unproven, as multiple drug abuse leading to paranoid symptoms does not appear to have been carefully considered nor tested for in the usual way by the screening of blood or urine.

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SIR: I am concerned by the conclusion drawn by Drs Thomas and Szabadi in their case report of paranoid psychosis in AIDS (*Journal*, November, 1987, **151**, 693–695); they state, "in every patient presenting with a psychosis of unknown origin and a history of intravenous drug abuse, AIDS should be suspected and the test for HTLV III antibodies be performed".

It should of course be the reflex of any competent psychiatrist to perform physical investigations in cases of paranoid psychosis, in order to exclude physical illness of a variety of sorts. It is equally clear that there was little doubt from the clinical presentation of the patient described that he was indeed physically, as well as mentally, ill. However, to sanction the determination of HIV antibody status seems

to me to have been a questionable step to take. There was no evidence that this assisted the treatment of the patient in any way. He was not treated with AZT (zidovudine). His management from the staff's point of view was no doubt vigilent with a view to the risk of viral infection, but this should have been so in any case. I cannot see the merits of determining HIV status in the patient described, and I would be interested to know whether he was able to consent to the procedure.

Whatever the merits in an individual case, there are no grounds for extending the idea of HIV screening in paranoid psychoses. The issue of consent in initiating this examination is paramount and the obtaining of consent in a deluded patient must be highly contentious. It may indeed be correct that a diagnosis of HIV infection should be entertained in a case of paranoid psychosis where a previous history of drug abuse or sexual exposure to the virus is suspected. However, the testing of patients in order to gratify one's desire to make a diagnosis must be resisted. The practical guidelines recommended by the BMA (at least its official guise) emphasise that consent must be sought to HIV testing, and while the legal position may be unclear, the ethical issues demand caution at the very least. Psychiatrists should be especially sensitive to these issues, and it is disappointing to find insensitive recommendations expressed in this way and published without restraint being imposed by the referees or editor.

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SIR: We thank Drs Johnson and Goodwin for their careful reading of our case report. We agree with Dr Johnson that multiple drug abuse may be associated with paranoid psychosis. Our patient had a history not only of taking heroin, but also of abusing diazepam and chlordiazepoxide. There was no history of abuse of amphetamine, cocaine, psilocybin, or LSD. No drugs were abused by the patient during the three weeks prior to admission when he was receiving methadone detoxification, and urine screening at this stage detected only methadone. Therefore, there seems to be little evidence that we were dealing with a drug-induced paranoid state in this case.

Dr Goodwin takes exception to our recommendation that "in every patient presenting with a psychosis of unknown origin and a history of intravenous drug abuse, AIDS should be suspected and the test for HTLV III antibodies performed". He raises the question of consent by the patient to have the blood test performed. In the case of our patient, whose psychosis showed a fluctuating course, written consent was obtained at a time when the patient had reasonably good rapport with reality, and he was also appropriately counselled. However, we are aware of the problem of the validity of consent given by a psychotic patient (Thomas, 1987). It should be noted that this is an area where medico-legal opinions and recommendations shift quickly (Dyer, 1987), and it seems to us premature to take up an entrenched position regarding the ethical rights and wrongs for testing for HIV infection.

The current BMA guidelines say that all patients should give informed consent and that the justification for testing an unconscious or desperately ill person is open to doubt (Sherrard & Gatt, 1987). No comment is made about what procedure to adopt should the person be psychotic and unable to give informed consent. It is to be expected that guidelines will be drawn up in the future concerning HIV testing in psychotic patients; possibilities might be additional consent from a relative, opinions of two independent clinicians, or the use of the appropriate section of the Mental Health Act.

We have to take issue with Dr Goodwin's point concerning the clinical need to determine the HIV status of a psychotic patient from a high-risk group. There can be little justification for advocating ignorance when a simple test can shed light on the diagnosis. The fact that currently available treatments of HIV infection are only palliative should not absolve the clinician from the responsibility to pursue the diagnosis: if the test is positive, rational treatments can be instituted, and if the result is negative, the clinician has the duty to search for alternative causes of the psychosis. The establishment of the diagnosis has bearing not only on treatment but also on prognosis, of which the patient, and with his agreement his family, have the right to be informed, and appropriate counselling should be undertaken. The need for HIV testing in psychiatric patients has been further emphasised by recent reports that HIV infection may present clinically with psychiatric or neurological illness without the clinical features of AIDS (Navia & Price, 1987).

Finally, when dealing with a new disease, it is essential to map out the clinical picture and the natural history of the condition: it would be virtually impossible to institute treatment strategies without this information.

Thus, in our view, the pursuit of diagnosis in a psychotic patient from a high-risk group with a simple blood test cannot be labelled "insensitive", and the opposite course of action may be paramount