Attempts to control the epilepsy have tended to be thwarted by poor compliance, and there is more recent evidence of some EEG deterioration. We think that this case is another example of the association of right-sided epileptic activity with hypomania, occurring as an interictal phenomenon.

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SIR: I was very interested in the article by Barczak *et al* (*Journal*, January 1988, **152**, 137–139) describing three cases of hypomania following complex partial seizures. It reminded me of the following patient whom I saw originally two years ago. She had moved here from London.

Case report: She was a 40-year-old married woman with a five-year history of complex partial seizures since just before the birth of her second child. She had been investigated in Kent and later at the Maudsley Hospital, where investigations including EEG suggested an epileptic focus in the left temporal region, resulting from cerebral cortical venous thrombosis. A typical attack consisted of her becoming very quiet, then making repetitive hand movements, plucking at her clothes, smacking her lips, and speech becoming mumbled. The attacks were fairly frequent despite treatment with carbamazepine. In the past she had also experienced tonic/clonic seizures.

I was asked to see her urgently by the neurologist. Her husband had become very worried about her behaviour in the previous week. She had become increasingly emotional, her mood swinging from tears to euphoria. She had become preoccupied with religion and the fate of the world. One day, while taking the children to school, she became convinced that the school was evil, because its name was similar to the word hell. She believed the children were going to be murdered. She also had insomnia. Her husband reported that she had had a similar episode prior to her admission to the Maudsley, which culminated in a drug overdose. This second episode settled in a few days and she reverted to her usual self.

A few months later her husband telephoned me saying she had had three seizures, following which she had started acting strangely again. She had become very giggly and had not slept for two nights. She was again preoccupied with the end of the world and also guilt feelings about her past. Later she had become tearful and unable to cope normally. Once more, this lasted a few days before she reverted to her normal self.

It seemed to me at the time that these were short-lived hypomanic illnesses. I saw her last a year ago after an incident when she was reported to have dropped her trousers at a school function. This occurred when she was having frequent seizures, and seemed to be a form of automatism. Unfortunately her seizures remained frequent despite treatment with sodium valproate and carbamazepine. She has now moved to another area.

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Diethylpropion Hydrochloride-Induced Psychosis

SIR: We were most interested to read of the two cases of diethylpropion hydrochloride-induced psychosis reported by Carney (*Journal*, January 1988, **152**, 146) and we would like to draw attention to the similarities between those histories and two more patients who developed psychotic phenomena after taking appetite suppressants.

Case reports: (i) Mrs S., a 42-year-old computer operator, was referred to the psychiatric services for the first time after a two-week history of behavioural disturbance and paranoid ideation. She had multiple florid delusions, 2nd and 3rd person auditory hallucinations, and felt compelled to act upon the commands of these hallucinatory voices. Ideas of reference were marked; she believed that the television was spying on her and that people were staring at her. She was visually hallucinating. She had taken diethylpropion hydrochloride intermittently during the preceding year and was using it as an aid to weight loss before her illness developed. Her symptoms responded to chlorpromazine; she remains well at six months' follow-up, drug-free.

(ii) Mrs T., a 35-year-old divorcee with no past or family history of psychosis, presented with a one-week history of insomnia, restlessness and agitation, formed visual hallucinations, unformed auditory hallucinations, and persecutory ideation. Her symptoms began approximately 24 hours after ingestion of 25 × 30 mg capsules of phentermine taken as an impulsive gesture. On questioning, she believed that people had been spying on her through the windows of her flat. Her friends had been appearing before her eyes and then disappearing again. In 1983 she had been diagnosed as suffering from bulimia nervosa; there were no symptoms of eating disorders on this occasion. Three days prior to visiting the Emergency Clinic her GP had prescribed thioridazine (50 mg t.d.s.), and her symptoms had begun to recede from this point. She failed to attend for follow-up five days later.

A functional psychiatric disorder was unlikely in these cases because of the ages of onset, the negative family histories, and the patient's well-integrated premorbid personalities with preserved social functioning. There was a clear temporal relationship between drug usage and onset of symptoms, which resolved rapidly when the drug was withdrawn. These drug-related florid paranoid illnesses with

visual hallucinosis are typical of the amphetamine psychosis first described by Connell (Maudsley Monograph 1958). This problem is a seriously under-reported side-effect of such drugs, and highlights the need for extreme caution in their use.

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The Place of Benzodiazepines in Psychiatric Practice

SIR: I am concerned that, in spite of the provisos mentioned, the paper on benzodiazepines by Tyrer & Murphy (*Journal*, December 1987, **151**, 719–722) will, in effect make a further contribution towards inhibiting the judicious and careful use of these drugs in appropriate cases based on experienced clinical judgement. As the authors state, patients are already "being encouraged to sue doctors for making them dependent" (on benzodiazepines). A sense of proportion is surely required here.

There are still many patients with chronic anxiety symptoms who do not respond to expertly applied alternative therapeutic techniques and, especially if "over 50% can stop their medication without withdrawal problems" and "... from present evidence there is no unequivocal permanent handicap caused by benzodiazopines in short or long-term dosage", it seems to me that clinical psychiatrists should have the courage to publicise these points in a responsible manner so that the media in particular and the public in general are better informed on these important problems.

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SIR: Our comment about the medical and legal implications of prescribing benzodiazepines was made to draw psychiatrists' attention to the image of benzodiazepines portrayed in the media. If patients are going to sue doctors for prescribing benzodiazepines, the profession needs to be appraised of this fact, if only to ensure that adequate records are kept of consultations involving drug prescription. Currently we know of some 400 patients in the United Kingdom who have approached solicitors because of problems they have had with benzodiazepines. We agree with Dr Silverman that it is right to draw attention to the benefits as well as the risks of benzodiazepines, but if the use of these drugs is injudicious and careless the consequences could be serious.

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Neurosyphilis and Psychiatry

SIR: In their recent report of a patient with neurosyphilis, Brooke *et al* (*Journal*, October 1987, **151**, 556) stress the importance of serological screening tests for syphilis in psychiatric patients whose mental state suggests an organic component. We have reviewed the cases of neurosyphilis presenting to the psychiatric unit of Tygerberg Hospital, the results of which serve to emphasise this view. Of 4314 consecutive admissions to the psychiatric unit between January 1983 and June 1987, 53 had a positive cerebrospinal fluid treponemal antibody absorption test. Thirty-two (0.74% of all admissions) satisfied criteria (Burke & Schaberg, 1985) for a diagnosis of neurosyphilis; of these, 16 were suffering from acute, treatable psychiatric conditions, namely delirium ($n=6$), mania ($n=5$), hallucinosis ($n=4$), and depression ($n=1$). These data suggest that, especially in developing countries such as South Africa, routine serological tests for syphilis in psychiatric patients remain essential.

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Reference

BURKE, J. M. & SCHABERG, D. R. (1985) Neurosyphilis in the antibiotic era. *Neurology*, **35**, 1368–1371.

Heterogeneity in Sporadic Schizophrenia

SIR: Lewis *et al* (*Journal*, September 1987, **151**, 306–314) have recently reviewed their original hypothesis (Murray *et al*, 1985) that the presence or absence of a family history identifies subgroups of greater aetiological homogeneity within schizophrenia. While their own data on ventricle brain ratios (VBR) in schizophrenic patients without a family history of major psychosis being larger than those with a family history (Reveley *et al*, 1984) are in support, results from other studies are not consistent