accident at age 10. Both patients responded well to benzodiazepines. Compliance had been a problem in both cases. Previous investigation had revealed lesions in the right temporal lobes in both cases. These are two more cases of hypomania in association with uncontrolled epileptic activity in the right temporal lobe. In both cases, increased epileptic activity was followed by a post-ictal mood change.

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## Spectrum Concept of Neuroleptic Malignant Syndrome

SIR: The report by Adityanjee *et al* (*Journal*, July 1988, **153**, 107–111) and their discussion of the concept and diagnosis of neuroleptic malignant syndrome (NMS) brought to mind my recent first encounter with this reaction, outlined in the following case report.

*Case report:* A 15-year-old girl was admitted to our unit in an excited, apparently psychotic state, diagnosed initially as hypomania. She was treated initially with chlorpromazine, which failed to control her. Haloperidol was substituted, and she made a rapid recovery and was discharged without medication. After a short while, the original symptoms re-emerged and she was immediately recommenced on haloperidol as an out-patient. About 5 days later she was referred for admission, with a history of dysphagia, oral thrush, and withdrawal. On this occasion she was drowsy and mute. There was marked 'lead pipe' muscular rigidity, but a tremor accompanied any attempted voluntary movement. She appeared flushed, but had only a mild pyrexia of 37.5°C. Blood pressure was normal, but the pulse rate was raised, both fluctuating significantly during initial observation. Non-response to intramuscular procyclidine raised our suspicion of NMS. All medication was discontinued, and she was transferred for in-patient medical care. The girl recovered without active treatment within ten days. Investigations revealed no leucocytosis or other abnormality, although serum creatine phosphotinase (CPK) was not assessed.

Days after this recovery, a relapse of the original illness occurred and was successfully treated with a brief course of ECT. So far the patient has remained well on lithium.

We made the diagnosis of NMS satisfying the suggested criteria of Kellam (1987): muscular rigidity, altered consciousness, and 'vegetative dysfunction', including pyrexia of $\geqslant 37.5$°C, changes in pulse, blood pressure, etc. However, this case, in common with two of the three cases described by Dr Adityanjee's group, fails to meet their suggested minimum requirements for the diagnosis, which include a pyrexia of $\geqslant 39$°C plus at least two of the following: tachycardia, rapid respirations, blood pressure fluctuations, excessive sweating, and urinary incontinence. Nevertheless, Dr Adityanjee *et al* refer to many other reports of idiosyncratic reactions to neuroleptics which comprise some, if not all, of the above criteria. Clearly, neuroleptic drugs are capable of producing a variety of unwanted effects, the 'pure' syndrome being by no means always the rule. In addition, NMS is clinically indistinguishable from lethal catatonia, described in psychosis, and from malignant hyperthermia, seen in response to some anaesthetic agents, and is not specific to the use of neuroleptic drugs (Kellam, 1987; Abbott & Loizou, 1986).

I accept Dr Adityanjee *et al's* argument for clinically separating NMS from the commonly encountered extrapyramidal side-effects because of the important implications for treatment, but I do not believe that this is a justification for adopting a narrow concept of NMS, as they suggest. I doubt the validity of regarding NMS as a distinct clinical entity, and suggest that all that is required is that clinicians are aware that the signs which comprise the syndrome can occur, so that early detection will lead to discontinuation of the drug and initiation of appropriate treatment with, hopefully, the avoidance of fatality.

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## Psychotherapy of the Elderly

SIR: I am disappointed by the dearth of psychiatric literature written and researched in Britain on the subject of psychotherapy of the elderly. Most of the literature has originated from American psychodynamically oriented psychiatrists and psychologists. Freud (1905) wrote: "The age of patients has this much importance in determining their fitness for psychoanalytic treatment, that, on the one hand, near or above the age of fifty the elasticity of the mental processes, on which the treatment depends, is as a rule lacking – old people are no longer educable – and, on the other hand, the mass of material to be dealt with

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