Following the drowning of a grandchild, she presented to psychiatric care in the USA in 1984 with a 'major depressive disorder with psychotic features'. She responded to tricyclics and neuroleptics. This was followed by a relapse of her depression with a 'paranoid psychosis' in 1985 after the death of another grandchild. She was treated with electroconvulsive therapy (ECT). Having returned to England, she suffered a further depressive illness in 1988 which featured nihilistic delusions, evidence of short-term memory loss, and behaviour such as throwing herself on the floor or lying across chairs. She responded slowly to tricyclics and antidepressants. Her face was mask-like and her responses were slow. Her recovery was limited and a presumptive diagnosis of multi-infarct dementia was made based on the cognitive deficits of disorientation, short-term and long-term memory loss and dyscalculia together with the NMR report of 1985 quoted above.

A serum autoantibody screen performed in 1990, however, revealed markedly abnormal homogenous autoantibodies suggestive of SLE. This, together with the NMR report of microinfarcts in 1985, suggests that a single diagnosis of SLE would account for this woman's six-year psychiatric career. It is of note that she had no family history of SLE, nor psychiatric disorder, and that her past medical history showed no manifestation of SLE in any other bodily system. Her pre-morbid personality was that of a religious, outgoing and friendly woman, used to public speaking and passionate about her garden.

There are echoes between this case and the earlier one described by Dr Green – both are manifestations of solely cerebral SLE diagnosed after a career of affective illness. In the early stages, carers and case notes of both cases refer to 'histrionic', 'hysterical', 'negativistic' or 'paradoxical' behaviour. The later stage of both cases appears to be characterised by movement disorders, one being a focal athetosis and the other a strange gliding gait and Parkinsonian facies.

If SLE can be seen twice in the psychiatric catchment area of Liverpool, it may follow that there is a much larger number of cases elsewhere, remaining as yet undiagnosed. If the diagnosis can be made and a series established then perhaps we will be that nearer a treatment for this most disabling condition.

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Reference

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A HUNDRED YEARS AGO

The non-restraint question

We were under the impression that the discussion between Dr Yellowlees and Dr Alex Robertson had exhausted itself in our last number. Each physician had fully and freely expressed his views on a subject in regard to which they honestly hold different opinions. To continue the discussion would, we think, be little more than a repetition of the same statements, if not the same words, without adding any real force to the arguments employed by these able combatants. Dr Robertson, however, wished to make it unmistakably clear that he regards "locked gloves" as one form of mechanical restraint. As he places in the same category "side arm dresses" and the "protection bed", and as Dr Yellowlees recommends their use in exceptional cases, Dr Robertson maintains that he was not in error referring to "the considerable use of mechanical restraint" advocated by him. Another statement Dr Robertson wishes to make, which is, that although he has been connected with an asylum which during the last five years has not had a larger number of patients than 125, it was, during many years previously, licensed for 248 patients, a large proportion of whom were dangerous, both in respect of suicide and homicide.

Reference

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