

Cognitive functions and fall-related fractures

SIR: We assessed the cognitive function of elderly patients admitted exclusively because of fall-related fractures. All were living at home at the time of the accident. They underwent a full physical examination on admission, together with a battery of psychometric tests to assess cognitive function: the Mini Mental State Examination (MMSE; Folstein *et al*, 1975), Benton's (1960) test, and Rey's (1942) complex figure copy and recall. There were 120 patients, with a mean (s.d.) age of 81.4 (8.2) years (110 women, mean age 81.2 (8.1), median 83; 10 men, mean age 82.8 (8.5); median 84). Most patients (114/120, 95%) had previously had a fall, and 44 (38%) had previously had fall-related fractures.

Only 12% of our population had a normal MMSE score. The mean MMSE result was closer to a dementia score than to a simple mental deterioration (18.92 (6.45); normal value, over 25). Furthermore, performance on Benton's test for non-verbal cognitive functions was poorer than expected on the basis of the MMSE (11.03 (4.91); normal value, over 25), as was the Rey copy test (14.84 (9.94); normal value, over 30) and the Rey recall test (4.55 (4.57); normal value, over 22). These results are in marked contrast with epidemiological data suggesting that only 20% of 80-year-olds suffer from dementia. Fall-related fractures and impairment of cognitive functions are thus strongly correlated.

For all elderly people seen for falls, with or without loss of consciousness, the cause of the fall should be examined. Low scoring in psychometric tests is a major risk factor for falls.

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Alcoholism in Kuala Lumpur General Hospital

SIR: The prevalence of alcoholism in hospitals has generally been reported to be between 10 and 30% (Moore, 1971; Jariwalla *et al*, 1979; Jarman & Kellet, 1979). This study attempted to identify the prevalence of alcoholism and undetected alcoholism in the General Hospital, Kuala Lumpur, and to describe some demographic trends.

Patients from the medical, surgical and orthopaedic wards were screened by the CAGE ($n=621$) (Bush *et al*, 1987); a total of 264, which included all positive by the CAGE and an equal number of negatives who were drinkers, were interviewed blindly by the author using DSM-III-R (American Psychiatric Association, 1987). Doctors were asked whether they knew the patients were excessive drinkers or not.

Sixty-six (11%) of the patients were alcohol abusers/dependents by DSM-III-R criteria, but only 21 (3%) had been detected by doctors to be drinking excessively. Thirty-five (53%) of the 66 were Indians, 13 (20%) were Chinese, 13 (20%) were Malays and 5 (7%) were others (Eurasians and other minority groups).

The overall drinking population comprised 95 Indians, 92 Chinese, 65 Malays and 12 others; of the non-drinkers, 54% were Malays, 22% were Indians, 21% were Chinese, and 3% were others. The prevalence of alcoholism in this hospital population is 11%. Indians appear to be more vulnerable to the effects of alcohol; it also appears that doctors have a stereotype of the excessive drinker as being poor, male, Indian and ill. Excessive drinkers not fitting this description were missed.

No female alcoholic was identified in this study, although 14% of the drinkers were women; the stigma and taboos associated with Asian women who drink may explain this.

The prevalence of alcoholism in the general population in Malaysia is unknown.

The majority in this study came from social class 3 and below, which corresponds to the general occupational distribution of the population in the hospital and in the catchment area serving it.

The Indians in this study were mainly immigrants from South India, and one wonders if such racial trends are noticed in other Asian immigrant populations.

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A man who does not use his arms

Case report. Mr X initially presented asking for amputation of both arms. He was in his 30s, small, and barefoot but otherwise fully clothed, although his trousers were incompletely fastened. His arms were held underneath his shirt, behind his back, his hands resting on his buttocks inside his trousers, while the sleeves of his jacket hung loosely at his side. He wore his wristwatch on his ankle and during conversation gesticulated with his feet. He used his feet to open doors and reported using them to eat, type, and drive. He described his problem as: "I can't - or rather I won't - use my arms". He was seeking psychiatric support for surgical amputation. He had thought of waiting beside a railway line with his arms over the tracks but feared that this method would also kill him. He subsequently presented on two occasions with a belt fastened around his left arm as a tourniquet, which he removed on request. He refused psychiatric assessment until he needed medical support to train on a disabled person's scheme.

He described feeling that his arms were alien to him from the age of nine, when he had seen television documentaries about thalidomide victims. When alone he would secretly use his feet to carry out actions such as opening cupboards. From his early teens there were short periods when he would lose power in both arms. This would happen suddenly, preceded by anxiety, and lasted for only a few minutes. In his 20s he began to avoid use of his arms in public, and to make contact with disabled people. In his early 30s he was dismissed from his job in a building society when, while visiting the home of a client, he exposed himself after unfastening his trousers to emphasise the problems of his disability. At that time he was referred to a psychotherapy group by a psychiatrist, but refused to attend.

He blamed his problem on lack of love from his parents as a child, but his parents described his childhood as normal, although they remembered that he became argumentative and arrogant during his teens. They had only recently learned of his lifestyle.

He was reluctant to discuss his sexual history but did say that as a teenager he masturbated by rubbing his body on his bed sheets, without using his arms. In his early adult life he had one long-term girlfriend, and he was married for a short time during his 20s. He refused permission to contact his ex-wife.

He now lives in a flat adapted for a previous tenant who was disabled. He dresses by manoeuvring his body into clothes which are hung up to allow this. He uses his feet for most other activities. He eats ready-made meals from the floor and drinks through a straw. When he is shopping, a sales assistant carries his basket. He has not worked for several years but currently attends court with a solicitor who (unsuccessfully) defended his driving licence, and he intends to study law.

He is often irritable, and at times condescending or over-familiar. His speech is meticulous and circumstantial. His mood is objectively and subjectively euthymic. He has no abnormal beliefs about the function or appearance of his arms and is clear that he chooses not to use them. He has no other abnormal beliefs or experiences. His intelligence and cognitive state appear normal. Physical examination, neuropsychological testing, and full investigation have been normal.

There is no evidence of an organic disorder or of psychotic illness or major affective disorder. His symptoms are similar to the non-delusional overvalued ideas described by McKenna (1984). His presentation has some features in common with dysmorphophobia (Andreasen & Bardach, 1977) but is atypical in that he accepts there is nothing wrong with the appearance of his arms.

Some features, such as repudiation of bodily parts and the history of an impoverished childhood, are similar to those described in non-psychotic genital self-mutilators (Greilshemer & Groves 1979). His conscious motivation makes hysteria unlikely, but malingering seems an inadequate explanation. The psychological factors that have led him to present in this way are similarly unclear. Currently, reinforcement is being provided by the concern of mental health services. An alternative view of this entrenched pattern of behaviour is that Mr X has found himself in a predicament from which he cannot escape (Taylor, 1979).

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