DEAR SIRS

Coakley (*Psychiatric Bulletin*, 1992, **16,** 111) makes interesting comments on a case reported by Anderson & Bach-Norz (*Psychiatric Bulletin*, 1991, **15,** 574) to illustrate the problems in the use of guardianship. We would agree with Dr Coakley that the case description is very like that of other described cases of Diogenes syndrome (Clark *et al*, 1975) and cases we have seen ourselves. Debate then arises regarding how such cases should be managed. Most psychiatrists regard this as a form of personality disturbance and not as an "illness". Hence Dr Coakley's assertion that use of the Mental Health Act may be inappropriate.

However, in a recent synthesis of the literature concerning dementia of frontal lobe type and Diogenes syndrome, Orrell & Sahakian (1991) make an interesting comparison between these two conditions. They suggest that Diogenes syndrome may be a form of frontal lobe dementia. If this is so then it should be regarded as an illness and managed appropriately.

The case of a 62-year-old man recently referred to us helps to illustrate this. He had been found living in appalling, insanitary conditions and admitted to a medical unit with hypothermia. On recovery he refused to permit access to his house to allow his living conditions to be improved. In his mental state there was little to find, apart from some mild perseveration in relation to the topic of conversation. He was fully orientated and bedside cognitive testing did not reveal any abnormality. Detailed neuropsychological testing revealed specific deficits on tests relating to frontal lobe function and a CT scan showed some cortical atrophy. Thus this gentleman, who presents with a pattern of behaviour that would fulfil the description of Diogenes syndrome, with no initial clinical evidence of other psychiatric disorder, has clear evidence of organic brain dysfunction.

We would like to point that Diogenes syndrome is just that – a syndrome, i.e. a description of a certain set of symptoms and/or behaviours. This has no particular implication for aetiology and indeed until one is established we should remain open minded. Our case, taken in conjunction with the comments of Orrell & Sahakian (1991), supports the view that this syndrome has an organic aetiology.

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Patients too intoxicated for assessment

DEAR SIRS

Drs Huckle and Nolan (*Psychiatric Bulletin*, 1992, **16,** 82–83) report an audit of referrals to an emergency psychiatric assessment clinic. A similar service is provided at St Tydfil's Hospital and has likewise been subjected to a detailed audit by staff there. In general the findings have been similar to those from Whitchurch Hospital but one particular problem deserves further consideration, that presented by patients who arrive for assessment intoxicated by alcohol. Drs Huckle and Nolan hint at this where they state that being "too intoxicated for assessment" was one of the main reasons given by junior staff where they thought the referral inappropriate.

In St Tydfil's Hospital 16% of those seen over a two-month period were intoxicated with alcohol at assessment. The vast majority had been referred by GPs or the local casualty department. It was exceptional for such cases to result in admission and, although many were directed to other non-urgent services, the feeling among nursing and medical staff is that the subsequent uptake rate hardly justifies the time spent on assessment. One solution is to breathalyse patients on arrival, but often it seems unfair to deny them the opportunity to see the doctor after they have arrived on the ward. An alternative is to ask referrers to make their own assessment of whether the patient is intoxicated, although in practice this rarely seems to result in an accurate judgement. I would be interested to hear how this has been tackled elsewhere.

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Value of meditation

DEAR SIRS

The report by Farmer & Ramsay about the use of meditation for the staff at the University College Hospital Drug Dependence Unit (*Psychiatric Bulletin*, 1992, **16,** 80–81) confirms my own understanding. For ten years in the late '60s and early '70s I ran one of the London drug dependency clinics single-handed (no nurse, no social worker), seeing patients in the evening so as not to jeopardise their tenuous hold on employment. Consequently I seldom left until after 11 at night and sometimes not until after midnight.

Fortunately I never felt the slightest degree of burnout and this I associate with practising meditation for two half hours each day. It's like sunbathing, only the sun is inside, not outside.

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