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LETTER TO THE EDITOR

Charles Bonnet syndrome and dementia

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To the Editor:
We read with interest the case described by Hori et al. (1) of a visually impaired 89-year-old woman with symptoms suggestive of Charles Bonnet syndrome (CBS), which is characterized by visual hallucinations and partial insight in the absence of other psychotic symptoms (2). The need for decreased visual acuity remains controversial (3). The patient's MMSE score was 18 but the authors concluded that this only indicated mild cognitive impairment and she was not demented. Such a conclusion should be reached cautiously, given that such a score usually indicates significant cognitive impairment and no further neuropsychological testing was presented by the authors. According to the criteria (4), we would suggest that the patient has a possible Lewy body dementia (LBD), given her cognitive impairment and visual hallucinations, and that this diagnosis would override a diagnosis of CBS.

Furthermore, atypical antipsychotics may have a role in the treatment of CBS in addition to donezepil (5). We describe an 82-year-old man who presented with 3 years of seeing people on his farm and around his house conducting various religious festivals. He also saw dogs and cats that he knew were not there because his hand went through them when he tried to touch them. There were no other psychotic or affective symptoms and he retained partial insight into his condition. There was no past psychiatric history, but his brother had possible Alzheimer's dementia. He had had a left cataract treated 2 years previously, but retained good visual acuity in his right eye. He had also been diagnosed with mild Parkinson's disease 1 year previously, after presenting with a right arm tremor and bilateral cogwheel rigidity, but had declined pharmacological treatment. When he presented with his hallucinations, he also reported difficulties swallowing, and on examination had bradykinesia and a decreased arm swing. He scored 26 on MMSE, scoring 10/10 orientation, 4/5 concentration, 3/3 registration and 2/3 on 5-min recall. On attention span he was able to recall six digits forward and five backwards, and the clinical interview and cognitive screening revealed no evidence of executive dysfunction. He was prescribed 1 mg/day risperidone and his visual hallucinations ceased without any deterioration of his Parkinson's disease.

A diagnosis of CBS and mild Parkinson's disease was appropriate given the patient's physical status, the severity of both conditions and the lack of other physical, psychiatric or cognitive features. Alcantara et al. (6) have emphasized that the diagnosis of CBS should be made when there are visual hallucinations both before the motor signs of Parkinson's disease and in the absence of anti-Parkinsonian treatment, which occurred in the above patient. We agree with Hori et al. (1) and Terao and Collinson (7) that clinicians should be vigilant for the emergence of either Alzheimer's dementia (AD) or LBD. However, once the diagnosis of AD or LBD is considered clinically to be either a probability or a possibility, the diagnosis of CBS should be subsumed under an appropriate dementia diagnosis.

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