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.

ALAN BYRNE

Unit 9
James Connolly Memorial Hospital
Blanchardstown
Dublin 15

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.

W. D. WALKER

Adolescent Unit
St Ann's Hospital
Nottingham NG3 6LF

References

ABBOTT, R. J. & LOIZOU, L. A. (1986) Neuroleptic malignant syndrome. *British Journal of Psychiatry*, **146**, 47–51.

KELLAM, A. M. P. (1987) The neuroleptic malignant syndrome, so-called. *British Journal of Psychiatry*, **150**, 752–759.

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

would prolong the duration of the treatment indefinitely." The research in the last decade highlights the beneficial effects of psychotherapy in the elderly population. There have been successful reports of nearly all modes of psychotherapy, including individual, group, marital and drama, family, and behavioural therapy.

We are only too aware of the changes that an ageing person has to make in trying to adapt to the altered dynamics of his or her life. Adjustments have to be made to family life when one child after the other leaves home and becomes independent. Marital relationships acquire new dimensions when they cannot use children to mask the problems which might be present in the relationship. Ageing may also give rise to anxieties about the loss or diminuation of sexual potency, or reproductive capacity. The psychological implications of retirement, loss of professional identity and work role, are evident. This may lead not only to lower income and a lower standard of living, but also to low self-image. One cannot ignore the anxieties and fears of becoming ill and dependent on others and the dread of losing mental and physical capacities. Finally, the ageing person may be haunted by the inevitability of death and increasing loneliness as close friends and relatives die, resulting in severe disruption to the psychological balance of this group of people.

Sorenson (1986) writes that the ageing process presents a challenge to the narcissism of the individual due to physical, social, and psychological changes and losses. There is a danger that mental health professionals may add to narcissistic trauma by underestimating elderly patients' potential for change. He emphasises further that the elderly are as susceptible to change as younger patients, and that one discovers during therapy that the aged patients are struggling, just as the younger ones are, with attempting to regain control in their lives and recover a sense of dignity for themselves. Psychotherapy can help them meet the formidable challenge that the ageing process presents to the sense of self.

I feel that the elderly population has been underserved by British psychotherapists. It is high time that we open our doors for this population, who are no less complicated than the younger population popularly accepted for psychotherapy. I feel that a combination of prejudice against the elderly by society and the psychotherapist, poor training in the field of geriatric psychotherapy, limited financial resources, mobility and transportation problems, and finally personal resistance, has been responsible for such a low interest in the field.

Finally, in the words of Vander (1983), "Psychotherapy with the elderly requires a concentration of one's own attitude towards the elderly, a knowledge of the various conceptual issues underlying work with the elderly, and careful planning of goals and interventions based on clients' needs. Using these tools the psychotherapist can experience satisfactions equal to or greater than those gained from the work with younger clients".

A. JAWAD SHEIKH

Midland Nerve Hospital
Elvetham Road
Edgbaston, Birmingham B15 2NJ

References

FREUD, S. (1905) *On Psychotherapy*. Standard Edition, Vol. 7, pp. 257–270. London: Hogarth Press.

SORENSEN, M. H. (1986) Narcissism and loss in the elderly. Strategies for an inpatient older adults group. *International Journal of Group Psychotherapy*, **36**, 534–547.

VANDER, S. Z. (1983) Psychotherapy with the elderly. *Journal of Psychosocial Nursing and Mental Health Services*, **21**, 25–29.

Quinine Psychosis

SIR: With reference to Jerram's report (*Journal*, June 1988, **152**, 864) of a case of quinine-induced psychosis, I report another case with a relationship between quinine and psychosis.

Case report: A 69-year-old lady was admitted with a four-day history of over-activity, talking excessively, insomnia, and grandiose delusions. She was elated, showed flight of ideas, and had no perceptual or cognitive impairments. There were no antecedent medical illnesses, social precipitants, or any new medication. She had had a mastectomy two years previously for carcinoma of the breast, and was taking tamoxifen (20 mg b.d.). She had been taking quinine sulphate (300 mg nocte) for one year, for night cramps, in addition to pilocarpine eye drops for glaucoma. These were continued on admission. Physical examination was normal. Full blood count, ESR, B12 and folate levels, ECG, liver and renal function tests were normal. X-ray chest and isotope brain scan were also normal, ruling out metastases. TSH levels were 7.4 mu/l; she was clinically euthyroid. A diagnosis of manic depressive psychosis, currently manic was made. She was put on chlorpromazine (400–600 mg/d) for about three weeks. Her agitation was controlled, but she continued to exhibit psychotic features such as taking off her clothes, posturing, and incoherence of speech. In view of her poor response to chlorpromazine and the fact that psychotic reactions to chlorquine are known, her quinine was stopped. She returned to her normal self in 48 hours and developed a sudden intolerance to chlorpromazine – drowsiness, oedema feet and postural hypotension. Chlorpromazine was tapered off over ten days and these symptoms cleared up too. An EEG done at this stage showed