In January 1985 we were contacted by journalists from *The Sunday Times* (20 January 1985) in connection with an investigation they were carrying out into the use of khat in Britain. They had found out that large quantities of the substance were being imported into London without restriction.

The Regional Drug Information Service informs us that no further cases have come to light in Liverpool, and it would appear that at present the use of the drug is mainly confined to certain ethnic communities. Possibly because of this it may be less likely to come to the attention of medical services.

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GOUGH, S. P. & COOKSON, I. B. (1984) Khat-induced schizophreniform psychosis in the UK. *The Lancet, i*, 455.

SIR: This case report (Critchlow & Siefert, *Journal*, February 1987, **150**, 247–249) does not accurately describe a typical case of khat psychosis. We reported three cases of catha (khat) psychosis (Dhadphale *et al*, 1981): our patients had paranoid psychosis with florid delusions which occurred in clear consciousness, and excessive use of khat was suspected as a possible causal agent. In a five year follow-up we did not find any relapse of psychosis in our subjects. Since then we have seen more than a dozen patients with khat psychosis, and all of them have shown a similar clinical picture as well as outcome.

As khat chewing is blamed for every social evil in our society by the lay press, our department has been involved in substantial research on various aspects of khat chewing (Omolo, 1985; Omolo & Dhadphale, 1987*a*). Our country grows and exports good quality khat leaves and a substantial number of our people in khat-growing areas chew khat for its amphetamine-like stimulant effect. Many use alcohol to counteract the sleeplessness which inevitably follows khat use (Omolo & Dhadphale, 1987*b*).

Critchlow & Seifert's case appears to us to be a mixed psychosis, probably toxic in origin, and due to several factors such as respiratory infection, possible morphine or dihydrocodeine use or abuse, or subtle malnutrition due to poor appetite and sleep deprivation – the latter two being the result of chewing khat. The authors should have inquired about the quantity of leaves chewed by the patient during the weeks prior to admission.

However, they have rightly alerted the medical and psychiatric communities in the UK to the possibility of khat being involved when a young person presents with a paranoid psychosis. Evidence of khat use may be found if the clinician examines the oral cavity of the patient for evidence of ulcers or stained teeth, which are common among habitual users.

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Capgras' Syndrome in a Patient with Dementia

SIR: We report a patient who typifies some of the issues raised by Kumar (*Journal*, February 1987, **150**, 251).

Case report: A 79-year-old woman presented with a three-year history of the gradual onset of impaired memory. Two years after onset her husband was admitted to hospital for a few days for a minor operation. On his return he noticed that his wife made repeated references to her 'first' husband, whom she claimed had died some years before. She now referred to her husband as her second husband, despite acknowledging the very close resemblance in physical appearance, name, and profession between the two. Even though the husband could not convince her of his true identity, she showed no hostility towards him; as she said, "the new man is quite nice to be with". The husband's attempts to remind her of their earlier married life were always met with the reply: "but I was married to John in those days". At the time of presentation this belief had persisted unchanged for six months.

On examination, she had moderate impairment of memory for recent and remote events. She was mildly dysphasic and dyspraxic and could not name, or recognise as familiar, any of the subjects in a Famous Faces test. She did not score above chance level on a forced choice test of facial recognition. There was no evidence of depression or other abnormal beliefs, and her insight was limited to concern about her poor memory. CT brain scan revealed mild ventricular dilatation and sulcal widening but other investigations were normal, and a presumptive diagnosis of senile dementia of Alzheimer type was made.

This case emphasises some of the problems with regard to the nosological status of Capgras' syndrome in the cognitively impaired. There may be a spectrum of disorders of recognition. In our case there was no suggestion that the patient believed her husband was an imposter or that he had been maliciously replaced. Our case is similar to those described by Pick (1903) in introducing the concept of reduplicative paramnesia. While resisting a psychoanalytical interpretation, and in the absence of evidence of focal brain lesions (Lewis, 1987), the sequence of events in the genesis of our patient's belief might be as follows: the couple are reunited after a separation but because of a combination of poor visual memory and failure of facial recognition the wife does not recognise her partner's face. However, a sense of familiarity is retained because of other cues, e.g. mannerisms, and has to be explained. The patient's interpretation of events may then take one of two paths: either a confabulation involving a 'duplication' of the same person experienced at two different points in time (or in two different settings as with Pick's cases), or a delusional elaboration that the original partner has been replaced by an imposter. This latter is the classic Capgras' syndrome and may arise more readily in patients with premorbid paranoid traits (Burns, 1986). The status of such phenomena in the cognitively impaired may have implications for treatment and requires further elucidation.

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ECT in the Elderly

SIR: The report by O'Shea *et al* (*Journal*, February 1987, **150**, 255–257) of cognitive improvement in a very elderly depressed patient treated with ECT is useful in that it reminds us that elderly people should not be denied an effective treatment solely on the grounds of age.

Clinical features which predict a good response to ECT in younger patients also predict a good response to ECT in the elderly (Fraser & Glass, 1980), and the presence of co-existing dementia does not adversely affect the efficacy and safety of ECT (Weiner, 1982). Age alone is not a contra-indication to the use of ECT (Benbow, 1985).

The clinical details quoted by O'Shea *et al* give little support to a diagnosis of dementia in their 91-year-old patient. She had previously responded to dothiepin, and the episode which led to the use of ECT seems to have been of less than 12 months duration. Her cognitive function was impaired as tested by the Mini-Mental State at a time when she had a frankly psychotic depressive illness, and improved as she recovered in response to treatment. This is not surprising. Fraser and Glass (1980) studied 29 elderly patients (aged 64–86 years) treated with ECT and found that they all had impaired memory function before treatment. Three weeks after ECT all scores had reached levels acceptable as normal. The clinical experience of many psychogeriatricians bears this out.

One problem is that the literature regarding the use of ECT in the very elderly is limited. In a study of 122 patients treated with ECT by the psychogeriatric service at the University Hospital of South Manchester only 16 were aged over 80 years and the oldest was a woman of 88 years (Benbow, 1987).

It is important that ECT is made available to elderly people with depressive illnesses, where the clinical features suggest a likely response and antidepressant drugs have not been successful or cannot be tolerated. Babigian & Guttmacher (1984) demonstrated a substantially decreased mortality risk in women over 75 years of age treated with ECT in comparison with a non-ECT group. Perhaps age could be regarded as an indication for ECT, rather than the reverse?

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