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correspondence

Idiopathic intracranial hypertension identified in a child seen in CAMHS

A 13-year-old was seen in child and adolescent mental health services (CAMHS) for school refusal, extreme separation anxiety, temper tantrums, headache, nausea, vomiting, lethargy, and aches and pains. She was overweight, bullied in school and had a past history of reflux heartburn and psychosomatic complaints for 2–3 years, for which she had been seeing paediatricians.

During her contact with CAMHS therapeutic group, she was isolated and difficult to engage. She was regressed in behaviour and relied a lot on her mother. Her family all along suspected an unidentified organic condition.

With the emergence of vision problems, her general practitioner referred her again to the paediatric team. Idiopathic intracranial hypertension was diagnosed and subsided after treatment with acetazolamide and lumbar punctures. She still has headaches and other non-specific symptoms.

It is known that idiopathic intracranial hypertension is a rare self-limiting condition generally lasting less than 12 months, and in children can present with psychological and non-specific symptoms (Kleinschmidt *et al*, 2000; Youronkos *et al*, 2000). There is 13–27% possibility of visual loss if untreated (Soler *et al*, 1998).

In this patient, given the long history of psychosomatic symptoms pre-dating the onset and persisting after treatment of the idiopathic intracranial hypertension, it is likely to have been a coincidental finding.

This patient illustrates that physical illnesses may arise in children with psychological problems and our dilemma in deciding how far to investigate non-specific symptoms, balancing against the risk of reinforcing somatisation. Regular joint working and consultation between CAMHS, educational services and paediatricians in such complex cases may be a way of sharing knowledge, identifying things early and improving patient care.

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Self harm – a culture-bound syndrome? Ghana and UK experience

Self-harm or parasuicide is generally believed to be rare in low- and middle-income countries. The subject was hardly mentioned, let alone taught, as a topic throughout my undergraduate medical training in Ghana. In my medical school clinical years and throughout my work as a house officer in the largest teaching hospital in Ghana, I never saw or head of a single case of self-harm. I later worked as a medical officer (hospital-based general practice) in a busy district hospital for 3 years and here too I never encountered such a case.

I am not aware of any publications from Ghana on the subject. There are a few papers from Nigeria, a neighbouring West African country. Eferakeya (1984) found the prevalence to be 7 per 100 000, whereas 2 years later Odejide *et al* (1986) found a 6-month rate of 2.6 per 100 000. These rates are very low compared with UK rates of 251 per 100 000 for males and 323 per 100 000 for females (Schmidtke *et al*, 1996).

I had a cultural shock in my first psychiatric senior house officer post in the UK when I quickly realised that self-harm was the 'bread and butter' of emergency psychiatric practice. The question that bothered me and still remains unanswered is whether this is a culture-bound syndrome.

Could it be that the extended family system as opposed to the nuclear family, religious beliefs, social services provision, individualism, materialism, issues of abuse, healthcare provision and other factors that are different account for the apparent differences in rates of self-harm?

Ghana does not have a free national health service; a so-called cash and carry system operates whereby patients pay for services. This has huge disadvantages, but one unintended advantage could be that the financial implications may act as a deterrent to self-harm unless the act is in response to psychotic phenomena. The attitude of healthcare workers is also important. Owing to huge pressures on health facilities and inadequate training of health workers in the assessment and treatment of self-harm, such professionals are, in my opinion, likely to be unsympathetic to patients who self-harm. Their distress may be viewed as self-inflicted and therefore not deserving professional care and attention. This in effect could result in such patients not being treated sympathetically and with dignity, leading to subsequent under-reporting of cases.

EFERAKEYA, A. E. (1984) Drugs and suicide attempts in Benin City, Nigeria. *British Journal of Psychiatry*, **145**, 70–73.

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Audit of antipsychotic prescribing in dementia

Soyinka & Lawley (*Psychiatric Bulletin*, May 2007, **31**, 176–178) report an audit of a crucial treatment in dementia. The finding that 54% of patients received an

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antipsychotic accords with an audit we conducted in which 49% of patients with behavioural and psychological symptoms of dementia received such treatment. These patients were living in care homes and were referred by general practitioners. We disagree that this represents a 'concerning trend of "medicalising"' such symptoms. These patients are probably at the severe end of a spectrum so it is not surprising that many require antipsychotics. We feel that many patients do benefit from these drugs. Even CATIE–AD (Schneider *et al*, 2006) report effectiveness of antipsychotics but suggest restriction to patients with minimal side-effects and where benefit is observed.

We disagree with the assumption that findings can be generalised across the country; 50% of patients in the report received typical antipsychotics compared with only 12% in our audit. We note that the National Institute for Health and Clinical Excellence does not distinguish between antipsychotic subtypes (National Institute for Health and Clinical Excellence, 2006) and we wonder if this reflects the growing realisation, referred to by Soyinka & Lawley, that cerebrovascular risk might be shared by all antipsychotics, not just the atypicals.

We have a designated community psychiatric nursing service for care homes, which improves quality of care with targeted antipsychotic use and prompt follow-up and liaison. All patients in our audit had a clear indication for treatment and 94% were reviewed within 3 months. We should use antipsychotic drugs when required to alleviate patient suffering and agree that documented review of patients on antipsychotic drugs is important.

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the college

Election of President – Notice to Fellows and Members

Fellows and Members are reminded of their rights under the Bye-Laws and Regulations.

Bye-Laws Section XI

1. The President shall be elected annually in accordance with the procedure described by the Regulations.

Regulation XI. Election of the President

1. The procedure for electing the President shall be as follows.

(1) As soon as may be practicable after the first day of June in any year the Central Executive Committee shall hold a nomination meeting and shall at such meeting nominate not less than one candidate and not more than three candidates.

(2) Between the first day of June in any year and the date which is four clear weeks after the nomination meeting of the Central Executive Committee, written nominations accompanied in each case by the nominee's written consent to stand for election may be lodged with the Registrar, provided that each such nomination is supported in writing by not less than twelve Members of the College who are not members of the Central Executive Committee.

(3) An election by ballot shall be held in accordance with the provisions of the Regulations.

The nominating meeting of the Central Executive Committee will be held on 12 September 2007 and the last date for receiving nominations under Regulation XI (2) above will therefore be 10 October 2007.

Professor Sheila Hollins is in her third year of office as President and is therefore not eligible for re-election.

Nomination forms are available from Sue Duncan (email: sduncan@rcpsych.ac.uk)

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