significance in the diagnosis or treatment of the disorder, which should be carried out in the usual way, i.e. a common feature of the psychiatric illness, with AIDS concern as a symptom, is hypochondriasis.

However, to avoid missing the obvious, one must not exclude consideration of the possibility of genuine cause for concern, as instanced by two recent male patients who were pathologically preoccupied and terrified that they might have picked up the disease. The first was a basically anxious somewhat hypochondriacal individual aged 60 years, who acknowledged past passive homosexual activity, and the second, a known manic-depressive aged 45 years, confessed his involvement with a prostitute abroad early in 1987.

The first patient required ECT, but the second fortunately responded to conservative anti-depressant therapy. Their affective disorders appeared to have heightened awareness of their past sexual contacts and possible consequences, rather than having caused the depression, which was not relieved by pre-test counselling and demonstration (fortunately) that they were HIV sero-negative.

Fenton (*Journal*, November 1987, **151**, 579–588) noted: "Individuals, not only those belonging to the high-risk groups, and known in some cases to be sero-positive but in others not, have developed a terror of and intense preoccupation with AIDS leading to multiple somatic complaints with a conviction of suffering from the disease". Perhaps, then, rather than the terms 'AIDS phobia', 'AIDS panic' or 'pseudo-AIDS', more apposite descriptive and diagnostically acceptable terms might be 'AIDS-concern' or 'AIDS-anxiety'.

Finally, from experience as a consultant AIDS counsellor, if psychiatry does indeed become a 'front-line' speciality in the management of AIDS victims, then provision for staff education (and allocation of financial resources) must be undertaken promptly, not least to minimise the number of 'secondary' cases of this AIDS-related condition among the caretakers.

M. SEGAL

Halifax General Hospital
Halifax
West Yorkshire

SIR: I refer to the letter from Riccio & Thompson (*Journal*, December 1987, **151**, 863) commenting on the earlier report by Miller *et al* (*Journal*, May 1985, **146**, 550–551). I wish to endorse their and others' views, particularly O'Brien's statement (*Journal*, July 1987, **151**, 127) that "What is important in patients presenting with excessive concern about AIDS, but without the disease, is not AIDS itself, but the underlying psychiatric state".

On reading the original report by Miller *et al*, I expressed my views (*Journal*, August 1985, **147**, 210) making this very point, adding: "Surely we need no further confusion in our already confusing and loose nosology. Do we call a depressive illness characterised in part by either hypochondriacal, overvalued or frankly delusional ideas of cancer (even if the patient has been recently in contact with a cancer victim) a 'pseudo-cancer' syndrome?" I included comments on the article by Miller *et al* that "What they actually describe, however, are two manifestations of psychiatric disturbance characterised *in part* by a fear of AIDS resulting in significant impairment but, contrary to the title of the article, they do not convincingly describe "the psychiatric symptoms resulting *from* a fear of AIDS", which they wish to refer to as 'pseudo-AIDS'. Both these patients were at high risk of contracting AIDS, and further I fear that the invention of a 'pseudo-AIDS syndrome', set against the backcloth of the difficulty of diagnosing AIDS itself in the early stages, might prejudice the diagnosis of AIDS where it actually exists".

It behoves us psychiatrists to be extremely prudent in our use of words, especially so when words might become labels, as labels not infrequently assume the quality of an entity. The history of psychiatry is replete with examples of how words have not clarified issues for us and our patients but have added to the problems which already existed!

BRON LIPKIN

Grovelands Priory Hospital
The Bourne, Southgate
London N14 6RA

Self-Inflicted Eye Injuries

SIR: The article by Rogers & Pullen (*Journal*, November 1987, **151**, 691–693) was of much interest as a psychiatric curiosity. Essays such as this, emphasising descriptive psychiatry, are a welcome relief from the usual stuff these days, much of it on epidemiology, surveys, questionnaires, and reports on patients with heavy reliance on complaints and symptoms, i.e. subjective phenomena generated by and reported by patients. It seems to me that a complaint is different from a symptom. In descriptive psychiatry we need to emphasise objective evolution based on signs.

Symptoms and signs often seem to be confused, and may be lumped together. 'Symptom' is from the Greek (*semeion*) and 'sign' from the Latin (*signum*). Stedman's dictionary defines semiology (semeiology) as symptomatology, which may be not strictly

https://doi.org/10.1192/S0007125000219004 Published online by Cambridge University Press

correct. Perhaps 'semeiology' (Gr. *semeion*) should be used to mean the knowledge of signs and 'symptomatology' (Gr. *symptoma*) the knowledge of symptoms. A Greek scholar could help out here! The French use the term *séméiologie* as a sort of cover-all term for both signs and symptoms.

Further to the paper by Drs Rogers and Pullen, I would draw attention to the weird sign in a photograph published by Kempf (1920), who was at the time working at St Elizabeths Hospital in Washington, DC. The illustration, Fig. 85 on p. 728, has the caption, "Elimination or castration of eyeball as a defense (*sic*) against eroticism". This photograph showed a man who has apparently pulled his left eyeball out of its socket. Unless the picture is a fake, this illustrated a case of self-inflicted dislocation of the eyeball. One hopes that the eye ultimately went back to where it belonged!

Enucleation of the eyeball, or dislocation, is to be differentiated from extirpation and damage short of removal from the orbit. Three cases of extirpation of the eyeball were drawn from the early literature by Gould & Pyle (1896), and there are no doubt other reported cases and many more which were not.

EDWARD L. MARGETTS

6171 Collingwood St
Vancouver, BC
Canada V6N 1T5

References

GOULD, G. M. & PYLE, W. L. (1896) *Anomalies and curiosities of medicine*, p. 735. Philadelphia: W. B. Saunders.

KEMPF, E. J. (1920) *Psychopathology*. St Louis: C. V. Mosby.

SIR: Rogers & Pullen's paper (*Journal*, November 1987, **151**, 691–692) reminded me of a patient.

Case-report: A 47-year-old married women with no history of psychiatric illness was referred to us in 1985 from the casualty department of the local county hospital. Early that evening the patient had tried to harm herself with a bread knife. She had tried to gouge both her eyes out and cut her wrist and legs. Fortunately her husband arrived at the scene and prevented her from injuring herself seriously. She had sustained sub-conjunctival haemorrhages to both the eyes and there were lacerations on both her eyelids. On examination of her mental status she was agitated and uncooperative. Her memory and orientation were intact. She had paranoid delusions, auditory hallucinations, and religious preoccupations. She kept repeating "I have to have a knife. I want to die for God. I have to take my eyes out". She refused to explain it. She was commenced on tablet chlopenthixol (25 mg t.i.d.). Her laboratory investigations revealed that she was grossly hypothyroid – free T_4 1.8 pmol/L, TSH 133.2 μU/ml. For this she was prescribed tablet thyroxin (50 μg daily). She made an uneventul recovery and was discharged from our care after four months. She has remained symptom-free.

The patient injured herself while acting on her delusions and had an underlying organic disorder. I agree with Rogers & Pullen that self-mutilation of the eye is not a single clinical entity, and we are told that it is usually associated with psychosis or organic disorders such as epilepsy, encephalitis, and diabetes. Self-inflicted eye injury secondary to delusions is understandable. What could be the possible explanation when it occurs in the context of organic disorder? I suggest that there may be a neurochemical factor involved.

I am grateful to Dr Fred. J. Bareen for giving me permission to report this case.

ASHOK. N. SINGH

St Brigid's Hospital
Ardee
Co. Louth
Eire

Paranoid Psychosis and AIDS

SIR: It is laudable that Thomas & Szabadi (*Journal*, November 1987, **151**, 693–695) have drawn attention to the possibility of an unusual presentation (paranoid psychosis) in a disease of enormous medical and social concern (AIDS). However, to my mind the case remains unproven, as multiple drug abuse leading to paranoid symptoms does not appear to have been carefully considered nor tested for in the usual way by the screening of blood or urine.

B. A. JOHNSON

The Maudsley & Bethlem Royal Hospital
Monks Orchard Road
Beckenham
Kent BR3 3BX

SIR: I am concerned by the conclusion drawn by Drs Thomas and Szabadi in their case report of paranoid psychosis in AIDS (*Journal*, November, 1987, **151**, 693–695); they state, "in every patient presenting with a psychosis of unknown origin and a history of intravenous drug abuse, AIDS should be suspected and the test for HTLV III antibodies be performed".

It should of course be the reflex of any competent psychiatrist to perform physical investigations in cases of paranoid psychosis, in order to exclude physical illness of a variety of sorts. It is equally clear that there was little doubt from the clinical presentation of the patient described that he was indeed physically, as well as mentally, ill. However, to sanction the determination of HIV antibody status seems

https://doi.org/10.1192/S0007125000219004 Published online by Cambridge University Press