The patients are often able to change the music by singing or thinking of a different tune, but cannot suppress it entirely. The hallucinations generally persist unchanged for many years, during which time the patients come to accept their unreal nature. Hallucinations of the spoken word occur only rarely and lack personal reference; neurological and mental state examination is otherwise normal apart from bilateral deafness due to otological disease. As in the unilateral case described by Khan *et al*, treatment with a hearing aid may be worthwhile.

It is likely that auditory hallucinations complicating deafness are a further example of 'release' hallucinosis secondary to sensory deprivation, analogous to visual hallucinations in blindness (Charles Bonnet syndrome) and phantom limb hallucinations following damage to peripheral nerves, although in both the auditory and visual hallucinations an additional central lesion (such as the parietal stroke in this case) may act as a final precipitating factor.

I am grateful to my grandmother for her help in confirming the genuine nature of the music described by this patient.

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Anorexia Nervosa and Infantile Autism

SIR: There are no reports in the literature of children with infantile autism who subsequently developed anorexia nervosa, although Gillberg (1985) has proposed that the two conditions might be related. We should like to report the case of a 16-year-old girl with anorexia nervosa who was previously diagnosed as having infantile autism.

Case Report: The girl was a only child; she was an irritable baby who would not sleep. Her eye contact was poor and she rarely smiled. She did not like being cuddled and failed to seek comfort from her parents. Furthermore, she showed little concern for the feelings of others and failed to form any friendships. Language development was abnormal; she did not use baby talk, and when she did learn to speak, her speech was monotonous, lacking cadence, and delayed echolalia was prominent. She never imitated other people, and did not use gestures when speaking. Her play was stereotyped, unimaginative, and solitary. At the age of four, she was diagnosed as suffering from infantile autism. A WISC test showed her to be of low-average intelligence.

At the age of 12 the girl started to gain weight and she attained the menarche. Other children's teasing prompted her to diet and avoid meals; if she did eat she would vomit afterwards. She tried purgatives at this time, but found them of little help. Apart from a short hospital stay, she was managed as an out-patient until she was 16, when she was admitted because of severe and sustained weight loss. She weighed 38.6 kg (70% of her ideal body weight). She felt that she was fat and wished to continue dieting. She would use all opportunities to dispose of food and was exercising excessively. She also gave a 12-month history of amenorrhoea. She fulfilled the ICD–9 and DSM–III–R criteria for anorexia nervosa.

The autistic child's obsessive desire for maintenance of sameness and the anorectic adolescent's obsessive preoccupation with food and the strict rituals associated with it has led Gillberg (1985) to suggest that the two conditions might be associated. He describes four families in which a boy had infantile autism and a near relative had anorexia nervosa. Apart from a higher than expected incidence of the two conditions occurring in the same family, he was unable to demonstrate any reason for the association. While this case supports Gillberg's hypothesis, it would seem likely that the association is due to chance.

Extreme food fads are well described in autistic children (Rutter, 1985). This case illustrates that anorexia nervosa does occur in adolescents with autism and that it is important that it is diagnosed, so that appropriate treatment can be given.

We would be interested to hear of any other cases in which these two conditions co-existed.

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