'PSEUDODEMENTIA' A MISLEADING AND ILLOGICAL CONCEPT

DEAR SIR,

A 62-year-old man was referred for assessment of cognitive impairment amounting to dementia. He also had moderate depression which was treated and he made a full recovery, only to become depressed again a year later with a clinical picture very similar to that seen previously. He recovered once more with treatment.

The conventional diagnosis of this state would be 'pseudodementia' i.e. a clinical picture of dementia existing without discernible organic brain disease. However, this diagnosis raises several points and it can be argued that 'pseudodementia' is a misleading and illogical term.

Modern definitions of dementia (e.g. Lishman, 1978) are in agreement about the basis for the diagnosis: it is an acquired global impairment of intellect, memory and personality, but without impairment of consciousness. Dementia exists when the criteria mentioned in the definition are satisfied. There is no presupposition of aetiology. Yet, a diagnosis of 'pseudodementia' would imply that confused aetiological and descriptive considerations existed in the clinician's mind during assessment. Logically, considerations of aetiology and pathology must follow the descriptive clinical diagnosis.

What 'functional' psychiatric illness really is must be considered moot at the best of times in the light of neurobiological data which continue to accumulate about the schizophrenias as well as depression. It need hardly be said that a satisfactory evaluation of the presence or absence of all brain pathology is unlikely to be made in the consulting room.

Depression may cause a clinical picture of dementia and also be a feature of the syndrome. But the investigation of a demented patient does not depend on ancillary symptomatology. Every demented patient deserves vigorous investigations and preoccupation with 'pseudodementia' or 'functional' dementia may only encourage delay in the investigation and management of other potentially treatable causes.

There is widespread feeling that dementia is malignant, terminal and incurable. A proper appreciation of the fact that a substantial minority (up to 20 per cent of cases in representative series) of those presenting with a picture of dementia in accordance with the modern definition can be treated with some expectation of success is a considerable morale booster.

For these reasons it is felt a case can be made for dropping the term 'pseudodementia'.

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Reference

LISHMAN, W. A. (1978) *Organic Psychiatry*. Oxford: Blackwell Scientific Publications.

NEUROSIS AND PERSONALITY DISORDER

DEAR SIR,

Tyrer *et al's* article, focussing on the relatioships between neuroses and personality disorder is to be welcomed (*Journal,* April 1983, **142,** 404–8). The authors are highlighting a frequent clincial problem fraught with research problems. Their attempts to define and demarcate such an area with the Personality Assessment Schedule (PAS) deserves plaudit.

However, I take exception to their interpretation of the General System Theory (GST) notion that as "neurosis and personality disorders constitute different levels of disorder, they should be regarded as separate". Indeed, their quoted reference, Gray, Duhl and Rizzo, 1969, emphasize that 'personality' should NOT be compartmentalized. Further, that "the more one examines the mental reactions of neurotics, the more one finds that there are no sharp lines of demarcation between the various types. Even the psychopathic personality is not always sharply demarcated from the neurotic" (p. 306).

I feel it is important to refer to the GST literature in discussing mental illness as Tyrer *et al* do. But equally important is to quote what the authors have written.

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GRAY, W., DUHL, F.J. & RIZZO, N. D. (eds.) (1969) *General Systems Theory and Psychiatry*. Boston: Little, Brown.

NEUROLEPTIC MALIGNANT SYNDROME

DEAR SIR,

With reference to a recent letter from Dr Cremona-Barbaro (*Journal,* January 1983, **142,** 98–9), reporting a case of neuroleptic-induced catatonia, I would like to bring to readers' attention a related but little-known complication of neuroleptic drugs. This is the Neuroleptic Malignant Syndrome (NMS) which has been reported in the French and American literature (Delay *et al,* 1960; Smego and Durack, 1982; Caroff, 1980), but there has been only a single British case report (Allan and White, 1972) up to now.

The NMS has been reported in connection with all the major tranquillizers but haloperidol and depot fluphenazines are most commonly implicated. Characteristic features of the NMS have been described in some case reports of patients receiving combined lithium and haloperidol (e.g. Cohen and Cohen,

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