

the approach towards German psychiatry should certainly be a most critical one.

HANS FÖRSTL  
ROBERT HOWARD  
OSVALDO P. ALMEIDA  
ADRIAN OWEN  
ALISTAIR BURNS  
JOHN O'BRIAN

*Institute of Psychiatry  
De Crespigny Park  
London SE5 8AF*

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*A full list of references is available on request from Dr Förstl.*

#### DEAR SIR

I thank Dr Förstl *et al* for their interesting and educational reply to my letter.

I wonder whether a syndrome has been described which might be applied to a psychiatrist who mistakenly identifies two almost identical syndromes? If so, perhaps *this* is what I am suffering from.

JOHN OWEN

*University Department of Mental Health  
41 St Michael's Hill  
Bristol BS2 8DZ*

#### *A register of Munchausen cases?*

#### DEAR SIR

Davey (*Psychiatric Bulletin*, March 1991, **15**, 167) adds his voice to those calling for a register of Munchausen cases. An interesting natural experiment with such a register took place some years ago when a knowledgeable patient with feigned Zollinger-Ellison syndrome frequented many hospitals demanding Omperazole, a drug under investigation with the details of all receiving patients held on a central register (Daly *et al*, 1989). This register enabled the patient's travels to be recorded in some detail and the authors comment that he would not have been identified without a register. However, in their letter they suggest that the diagnosis of factitious illness was made before consulting the register. Further evidence that a 'black-list' is not essential for diagnosis is provided by the fact that this same man had already made an inconspicuous entry into the medical literature (Lovestone, 1987).

The arguments against a register are strong. We should be cautious at any such breach of confidentiality and the legal complications may be serious. I wonder at the effect of having a list of patients with feigned physical illness on the practice of liaison psychiatry. It might contribute to increasing the "is it psychological or organic" type of referral – an often unhelpful dichotomy.

Although Davey calls for a register, he fails to actually state why. Making a diagnosis of Munchausen syndrome is in itself not particularly helpful to the patient as we do not know how to treat this condition. Protecting the patient from iatrogenic harm is important, but we can trust our colleagues only to perform invasive procedures when a diagnosis of Munchausen syndrome is not yet being considered – and hence a register not consulted. Jones (1988), quoted by Davey, is more explicit. The benefits of a register are economic and to be calculated in terms of cost benefit analysis. This is a poor reason – even in the new NHS doctors must strive to be more than accountants.

I suspect the reason underlying calls for a register lie within the physician and not the patient. Being 'caught out' or 'conned' is an unpleasant experience and it is understandable that doctors should wish to avoid it. In the spirit of Asher I would propose a fourth variant of Munchausen syndrome 'Homo connus phobia et registerphilia' – a disorder of doctors.

SIMON LOVESTONE

*The Maudsley Hospital  
Denmark Hill  
London SE5 8AF*

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#### *The use of carpets in geriatric and psycho-geriatric wards*

#### DEAR SIR

It is to be hoped that the eloquent and passionate protestations of Dr David Jolley (*Psychiatric Bulletin*, March 1991, **15**, 168–169) do not obscure the issues relating to the use of carpets in geriatric and psycho-geriatric hospital wards. He is partially right. Anyone who has worked in institutions caring for elderly people knows that offensive smells are not uncommon. While carpets are often associated with these smells, the smells are not confined to wards