jerry.seymour@rdash.nhs.uk, **Rashi Negi** Specialist Registrar in Old Age Psychiatry, **Christopher Flemons** ST4 in General Adult Psychiatry, **Matthew Impey** ST4 in General Adult Psychiatry, **NicolaThomas** ST4 in Forensic Psychiatry, **Rachael Witrylak** ST4 in Child and Adolescent Psychiatry,The Longley Centre, Sheffield

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Usefulness of routine blood tests in dementia work-up

Recent government reports and strategies have placed the diagnosis and treatment of dementia as a major priority within the NHS.[1] Guidelines issued from the Royal College of Psychiatrists and the National Institute for Health and Clinical Excellence on the assessment of suspected dementia suggested that all patients being referred to an old age service should receive blood tests. These include a full blood count (FBC), renal profile, liver profile, calcium, erythrocyte sedimentation rate (ESR), C-reactive protein, thyroid function tests, folate and vitamin B12.[2,3] In contrast, the Scottish Intercollegiate Guidance Network suggested that blood tests should be ordered on clinical grounds.[4]

An audit by our old age psychiatry service reviewed the laboratory and radiological results of 120 consecutively referred individuals with suspected dementia, all of whom received the blood tests suggested by the Royal College of Psychiatrists guidelines. None had reversible conditions diagnosed on computed tomography; 8.5% had low haemoglobin, 5.7% had a raised ESR, 19% had urea and electrolyte abnormalities and 14% had abnormal liver function tests. Just one patient had thyroid abnormalities and they were already on treatment for this; two had vitamin B12 and folate deficiencies and both individuals had nutritional problems due to advanced dementia.

Previous meta-analyses have shown that less than 0.6% of so-called potentially reversible dementias were reversible.[5] Our results suggest that laboratory investigations in dementia work-up are useful in the identification of medical problems that may worsen the patient's overall health or effect suitability to potential treatments. A third way should be taken between the guidelines incorporating their most useful recommendations. Simple tests like FBC, ESR, renal and liver function tests are useful in dementia work-up and should be routinely checked in all individuals with dementia. Less routine tests such as vitamin B12 and folate and thyroid function should only be completed based on clinical grounds.

1 Department of Health. *Living Well with Dementia: A National Dementia Strategy.* Department of Health, 2009.

2 Royal College of Psychiatrists. *Forgetful but not Forgotten: Assessment and Aspects of Treatment of People with Dementia by a Specialist Old Age Psychiatry Service (Council Report CR119).* Royal College of Psychiatrists, 2005.

3 National Collaborating Centre for Mental Health. *Dementia: A NICE–SCIE Guideline on Supporting People with Dementia and Their Carers in Health and Social Care.* British Psychological Society & Gaskell, 2007.

4 Scottish Intercollegiate Guidelines Network (SIGN). *Management of Patients with Dementia: A National Clinical Guideline (Scotland).* SIGN, 2006.

5 Clarfield AM. The decreasing prevalence of reversible dementias: an updated meta-analysis. *Arch Int Med* 2003; **163**: 2219–29.

***Kevin Foy** Senior Registrar in Old Age Psychiatry, Department of Old Age Psychiatry, Cavan General Hospital, Cavan, Ireland, email: kevinfoy@ireland.com, **Christian Okpalugo** Registrar, **Feargal Leonard** Consultant Psychiatrist of Old Age Psychiatry, Cavan General Hospital, Ireland

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Postmodernism and psychiatry

We have found that 'post-psychiatry'[1] tends to challenge our patience more than it does our ontological security. We agree with Bracken & Thomas[2] in that 'an increasing number of psychiatrists are seeking to work with different frameworks and to engage positively with the diversity of the user movement'. However, we doubt that post-psychiatry has much to contribute to this effort. Holloway's commentary[3] is generous with regard to the philosophical basis of the article. We believe that the application of the confused and confusing ideas that are known as postmodernism to psychiatric practice is deeply misguided and counterproductive.

The key contention in Bracken & Thomas's article is that organised psychiatry's recent attempts to form an alliance with service users and carers are inauthentic. A true alliance, according to them, requires that we abandon the biomedical perspective in general and descriptive psychopathology in particular in order to allow us to preferentially engage with radicals within the service user movement.

They briefly mention more conventionally minded service users and carers, but effectively dismiss their point of view. This apparent lack of respect for the diversity of opinion within the service user movement is entirely consistent with the postmodernist convention that everything, including 'facts' and 'truth', is relative. Where all perspectives are equally valid, the postmodernist is free to reject objectivity as an illusion, and to confine dialogue to the like-minded. For those of us who cling on to older humanistic ideas, the challenge in getting alongside patients is to take service users' experiences and views seriously whether or not they coincide with our own. Choosing to align ourselves with one particular perspective is patronising and simply repeats the mistakes of the past.

There is an inappropriate modishness (not to mention a lack of self-awareness) in Bracken & Thomas's free use of the term 'madness'. The word remains offensive to many service users, despite the fact that a minority choose to reclaim it. It is one thing for service users to define themselves as 'mad'. It is quite another matter for mental health professionals to use such terminology. There is a parallel here with the reclamation of racist words by some Black people. There is no degree of alignment with anti-racism that makes it OK for White people to use these terms. Similarly, it is hard to see how the interests of people with mental illness are furthered by urging psychiatrists to embrace the language of bigotry.

Bracken & Thomas sustain their argument by caricaturing the biological–mechanistic approach and suggesting that it is the primary conceptual framework of psychiatry. They make assumptions as to how the profession might respond to the challenges of the more radical parts of the service user movement, but they do not reference these responses, presumably because no one has made them. Although this type of argument is common in postmodernist writing (the discourse is implicit, so the lack of explicit reference to it is irrelevant), it is hardly likely to be persuasive to anyone with a reasonable level of independent mindedness.

In a fine piece of postmodern doublethink, post-psychiatry seems to want to be both part of psychiatry and separate from it. Bracken & Thomas deny being anti-psychiatry, anti-medical or anti-scientific but they reject the existence of any objectivity that transcends a particular paradigm and they regard descriptive psychopathology as oppressive. The logical corollary of their rhetoric is that when we are helpful to patients, it is despite the fact that we are psychiatrists, not because of it. If this is the case, why involve doctors in the care of people with mental illness at all? It is simply implausible and logically inconsistent to suggest that a Royal College of Post-Psychiatrists would somehow shrug off the encultured baggage of the doctor–patient relationship to lead us to a better place where the biomedical is replaced by something which is unspecified, but nicer.

A significant part of mainstream British psychiatry has long been working to develop a more humanistic, relevant form of practice that seeks to help people to solve problems in their lives rather than