References

BILDER, R. M., Mukherjee, S, RIEDER, R. O. & PANDURANGI, A. K. (1985) Symptomatic and neuropsychological components of defect states. *Schizophrenia Bulletin*, **11**, 409–419.

CROW, T. J., CROSS, A. J., JOHNSTONE, E. C. & OWEN, F. (1982) Two syndromes in schizophrenia and their pathogenesis. In *Schizophrenia as a Brain Disease* (ed F. A. Henn & H. A. Nasrallah), pp 196–234. New York: Oxford University Press.

PANDURANGI, A. K., BILDER, R. M., RIEDER, R. O., MUKHERJEE, S. & HAMER, R. M. (1988) Schizophrenic symptoms and deterioration: relation with computed tomographic findings. *Journal of Nervous and Mental Disease* (in press).

Behaviourally disturbed HIV patients

SIR: Davies (*Journal*, April 1988, **152**, 577–578) draws attention to the need to plan for facilities to care for mentally ill patients who have been infected with human immunodeficiency virus (HIV). A serious but not generally recognised problem exists in the UK in determining whether mentally ill patients are or are not HIV positive, as exemplified by the following case report.

Case report: A 52-year-old homosexual man with no previous psychiatric history was urgently admitted to hospital in disturbed condition under Section 135 of the Mental Health Act (1983), after he had behaved in a bizarre manner in his family doctor's surgery and refused repeated attempts to gain access to his home in order to interview him further. His mental state and behaviour were most unusual, being marked by extreme avoidance of all interaction or contact with ward staff and other patients. No history could be obtained from the patient, who simply ran away whenever approached by a member of staff, and flew into a rage when prevented from absconding. When left alone he would spend almost all of his time lying on his bed staring into space. He did not complain of any symptoms, but on one or two occasions he spontaneously shouted that his body was becoming taller, but would not elaborate when questioned. An organic disorder was strongly suspected, and after considerable difficulty a physical examination was performed, which was normal, and blood obtained for routine laboratory tests. These revealed an active syphilitic infection.

Examination of the cerebrospinal fluid was not possible at the time of admission, owing to the patient's mental state, and so a presumptive diagnosis of neurosyphillis was made, and treatment instituted with procaine penicillin (1.2 g daily for 21 days). At the same time antipsychotic drugs were given. These measures resulted in a considerable calming effect, but the patient remained very aloof, continued to strenuously avoid any human interaction, and began to settle into a stereotyped daily routine of wandering the hospital grounds, returning to the ward only at meal times when he insisted on laying the table for the other patients. A trial of intramuscular haloperidol decanoate did not influence his behaviour, but resulted in considerable disturbance and anger whenever the injection was due and even greater withdrawal in-between. Static neurological impairment, particularly of frontal lobe function, was strongly suspected, but could not be confirmed by psychometric testing owing to the patient's refusal to co-operate.

Seven months after admission his behaviour remained unchanged, but it was clear that he was losing weight and he soon developed vomiting. Despite very considerable practical difficulties, he was endoscoped and found to have extensive oesophageal candidiasis. The patient had from admission been considered to be at risk of HIV infection, and appropriate precautions had been observed, but laboratory confirmation of HIV infection had not been obtained as he was considered to be incapable of giving consent. As the emergence of an opportunistic infection strongly suggested AIDS or an AIDS-related condition, it was considered to be important to make a firm diagnosis. Advice was sought from a defence society which stated that without consent it would still be inadmissable to test for HIV.

This has resulted in a position where no firm diagnosis can be reached, and therefore it is unclear whether the patient has a poor prognosis for life and should be treated supportively, or has a static condition which will last many years and should be managed by a rehabilitation programme.

Psychiatric symptoms as a presenting feature of AIDS were first described by Nurnberg *et al* (1984), but it is only more recently that it has become recognised that HIV infections may exert a clinically obvious neurotropic effect before the emergence of symptoms of immunosuppression (Navia *et al*, 1986). It is therefore probable that psychiatrists will see an increasing number of patients with syndromes such as pre-senile dementia and psychotic illnesses due to HIV infection, but without lymphadenopathy, Kaposi's sarcoma or opportunistic infections. In these circumstances the only clue to the diagnosis will be the presence of antibodies to HIV and a history of risk factors. As the neurotropic effects of HIV infection become more widely recognised, it may be arguable that few of those infected are capable of giving their informed consent to testing for antibodies. If this position is accepted it will have seriously adverse effects for the care and management of psychiatrically ill patients suspected of HIV infection.

STEPHEN WOOD
SUSAN COPE
ANDREW HODGKISS
RICHARD O'FLYNN

Guy's Hospital
London Bridge
London SE1 9RT

References

NAVIA, B. A., JORDAN, B. D. & PRICE, R. W. (1986) The AIDS dementia complex: I. Clinical features. *Annals of Neurology*, **19**, 517–524.

NURNBERG, H. G., PRUDIC, J., FIORI, M. & FREEDMAN, E. P. (1984) Psychopathology complicating acquired immune deficiency syndrome (AIDS). *American Journal of Psychiatry*, **141**, 95–96.

Fear of AIDS

SIR: There have been some reports (Miller *et al*, 1985; Jacob *et al*, 1987) of psychological problems among people who are uninfected but fear that they might have AIDS (acquired immune deficiency syndrome). We would like to present a case of acute obsessional neurosis which responded well to clomipramine infusion.

Case report: A 27-year-old married man was admitted to the psychiatric unit as an emergency. He was very anxious and had obsessive ruminations about having developed AIDS. He had been worried about this since he borrowed a razor from a workmate who had had a recent viral illness and then heard rumours that this man might have AIDS.

He went into a local restaurant with his wife for a meal, and the manager of this restaurant later died of AIDS. His wife was presented with a rose by the manager, who pricked his finger on it, and he thought that he might also have pricked his finger on the same rose. He also thought that he might have had sex with the manager in the toilet, but he realised that this was absurd. Nevertheless, he went back to check the toilet in the restaurant to reassure himself that this incident did not occur. He denied having any homosexual experiences, but was worried that he might become homosexual because of these ruminations.

His wife was pregnant at the time, and he was afraid that he might have infected his wife and unborn baby with AIDS. He was self-accusative and thought of cutting his wrist, but was worried in case his wife would not be able to collect the insurance money. He then entertained the idea of committing suicide in such a way as it to appear accidental death. It was at this point that he was admitted to hospital.

There was no personal or family history of psychiatric illness. The patient had an uneventful school career and became a Scientific Officer. He was happily married with two children. He described himself as an "introvert and a worrying type of person". His only past medical history of note was a skull fracture sustained during a road traffic accident at the age of 20, after which he was unconscious for three weeks and later had an isolated epileptic seizure.

On examination he looked very worried and complained of having disturbed sleep, but his appetite was fair. He was well orientated and his memory was intact. HIV antibody tests were negative and EEG was normal.

He was diagnosed as suffering from an acute obsessional neurosis in an anxiety prone personality and commenced on daily clomipramine infusions.

He made a good symptomatic recovery after ten days and remained symptom-free on oral clomipramine (25 mg t.d.s.) eight months later.

This case presents a problem of differential diagnosis of anxiety state, depressive illness, delusional state, and organic condition. Although he exhibited the psychic symptoms of anxiety, the patient lacked the somatic symptoms which makes anxiety state unlikely. His anxious mood and lack of biological features exclude the possibility of a depressive illness. Retention of insight ruled out a delusional condition, and lack of cognitive and memory impairment made an organic condition unlikely. It would appear that the anxiety and some of the depressive features were inter-related to an obsessional illness.

There have been reports of the development of obsessional illness as a consequence of head injury (McKeon *et al*, 1984). In this case, the seven-year interval makes head injury an unlikely cause, but it may have affected his personality. It seems that the predisposed personality and media influence contributed to the genesis of his obsessional illness. This case also highlights the point made by O'Brien (1987) that a wide range of psychiatric illness may present with fear of AIDS, and shows that obsessional illness is one of them.

SIKANDAR H. KAMLANA
PETER GRAY

Department of Mental Health
West Cumberland Hospital
Whitehaven
Cumbria

References

JACOB, K. S., JOHN, J. K., VERGHESE, A. & JOHN, T. J. (1987) AIDS-phobia. *British Journal of Psychiatry*, **150**, 412.

MILLER, D., GREEN, J., FARMER, R. & CARROLL, G. (1985) A 'pseudo-AIDS' syndrome following from fear of AIDS. *British Journal of Psychiatry*, **146**, 550–551.

MCKEON, J., MCGUFFIN, P. & ROBINSON, P. (1984) Obsessive-compulsive neurosis following head injury: a report of four cases. *British Journal of Psychiatry*, **144**, 190–192.

O'BRIEN, L. S. (1987) Not a case of pseudo-AIDS. *British Journal of Psychiatry*, **151**, 127.

Mania in a Case of Eale's Disease

SIR: Eale's disease is characterised by recurrent retinal and vitreous haemmorhages with retinal perivasculitis, predominantly affecting the veins (Duke-Elder, 1967). There have been several reports of associated neurological involvement (Singhal and Dastur, 1976), but psychiatric complications are unreported. In this report we present a man with Eale's disease and neuropsychiatric complications.