Correspondence

Recurrent seasonal confusional psychosis: a diagnostic dilemma

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Psychosis that does not fit into schizophrenia or affective disorder categories is designated as atypical, schizophreniform, schizoaffective or acute and transient psychotic disorder (ATPD). There is no discrete category of 'confusional psychosis' in DSM-IV and ICD-10. This case report highlights the diagnostic dilemma of a case of 'recurrent confusional psychosis'.

Mr V. a 32-year-old married man, presented with 4 weeks history of looking confused, repetitive utterances of abusive words, an urge to pick up rubbish, occasionally hearing voices, jumping, sleep disturbance and urinary incontinence. Onset had been abrupt without clear precipitating factors.

His past history revealed nine such episodes in the previous 7 years. During the first 2 years, the episodes occurred in April and November, but subsequent episodes occurred only in November or December. During these episodes, the patient would utter abusive words without provocation, and have transient command hallucination telling him to jump. He would look confused and was not able to attend to conversation. His speech was monotonous and difficult to understand. He was slow in performing routine activities such as eating and bathing. While walking, he would suddenly make a posture as if he was picking up material from the ground.

In the current episode only, whilst fully awake, he had urinary incontinence on four occasions and fecal incontinence once. On a number of occasions, he made attempts to drink water out of the latrine. Mental status examinations revealed stereotyped movements of fingers and disorganized speech with echolalia and perseveration. His affect was perplexed. He was orientated to time, place and person. Concentration was impaired, but memory (short-term and long-term) was preserved. Organic work-up was negative. He improved over a number of months on no specific treatment.

Our patient exhibited core features of perplexity, compulsive behaviour and incoherent speech in the absence of emotional symptoms. He fulfils the diagnostic criteria of cycloid psychosis as defined by Perris [1]. Several studies have confirmed that the long-term prognosis of cycloid psychosis is favourable [2,3]. Some authors [4,5] have reported that it is possible to differentiate cycloid psychosis from schizoaffective psychosis and core schizophrenia, as well as its prognostic validity. We suggest that: (i) there should be a separate subcategory of acute confusional psychosis under ATPD; and (ii) ATPD should be further subdivided according to seasonal and recurrent pattern.

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Supporting and developing psychiatrists to take up leadership roles

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We were pleased to see articles in the *Journal* on leadership, management and team roles for psychiatrists in mental health services [1,2]. Concurrent with what we found to be the issues for psychiatrists at the Werribee Mercy Mental Health Program (WMMHP), Tobin and Edwards commented that '. . . most of the psychiatrists (surveyed) currently in leadership and management roles perceive they are inadequately prepared for the task and poorly supported by their colleagues' [1].

According to Herrman and colleagues, 'the way that psychiatrists and other mental health professionals work together has an impact on standards of clinical care and professional satisfaction' [2]. Czander [3] describes how organizational structures and leadership, and the quality of the relationships that people experience in working together, have a significant impact on how well people in the organization carry out their tasks. Applied to mental health organizations, it could be said that the delivery of mental health services will be enhanced where staff understand their roles, work well with each other, and have effective leadership.

The role of psychiatrists in the WMMHP was redefined to enable them to provide leadership in addition to fulfilling clinical responsibilities. As a result each program is headed by a manager and a psychiatrist and while they have different roles they are expected to work collaboratively in providing leadership. Most psychiatrists entering the service have varying degrees of clinical leadership experience but are not adequately equipped to take up a broader leadership and management role.

In order to facilitate the development of these skills we commenced a Psychiatrists' Leadership Development Program in January 2002. The group-based program aims to:

- Increase knowledge and understanding about organizational leadership;
- Develop a shared understanding of the scope of the psychiatrist;
- Provide a mutually supportive forum where psychiatrists can explore how to take up and develop leadership roles within the organization, and how to address the personal and organizational challenges in doing this.
- Assist psychiatrists from predominantly non-Australian backgrounds to explore and learn about cultural issues that may impact on taking up a leadership role in the organization.

The program has been well utilized by psychiatrists and feedback has indicated that it is achieving its aims. We believe it essential to recognize that leadership and management roles require a specific skill set, and that programs are required to develop those skills. We anticipate that this will have a positive impact on the work environment for psychiatrists, managers and other staff, and improve delivery of clinical services.

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Neuroleptic malignant syndrome: a case that may shed new light into the etiology and treatment

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A 34-year-old woman was hospitalized with a DSM-IV diagnosis of bipolar disorder, manic episode, with psychotic features [1]. She was given zuclopenthixol HCl 10 mg/day during the first 17 days of her admission. Thioridazine 50–100 mg/day orally was added on day 17, to decrease psychotic symptoms. Zuclopenthixol acetate 50 mg intramuscularly was also given on days 3, 7 and 21. On day 22, the patient developed muscular rigidity, dysarthria, coarse tremor, incontinence, imbalance, dysphagia, mutism, fever (up to 42°C), tachycardia (up to 140 beats/min), diaphoresis, and delirium. Following an extensive medical work-up, a diagnosis of neuroleptic malignant syndrome (NMS) was made according to DSM-IV [1].

All antipsychotic medications were discontinued. Bromocriptine, 15 mg orally daily, was started following 8 days of symptomatic treatment. Electroconvulsive therapy was started on the same day, to manage the patient's psychosis (seven sessions in total).

Laboratory findings included significant leukocytosis (up to 24 300/mm^3) and elevation of serum creatine kinase (up to 2841 U/L). There was a decrease in serum iron, from 55 mg/dL on admission, to a nadir of 26 mg/dL on day 14 of NMS. Haemoglobin (Hb) levels also decreased, from 10.6 g/dL on admission, to a low of 6.8 g/dL on day 14 of NMS. Serum ferritin increased from 3.1 mg/dL on admission, to a peak of 67.43 mg/dL on day 18 of NMS. There also was a rise in sedimentation rate, from 22 mm/h on admission, to a peak of 92 mm/h on day 21 of NMS (Figure 1).

As the patient's mental status and physical symptoms gradually improved during the following weeks, her biochemistry profile returned to the levels recorded at admission. Full recovery took 14 days. On day 39 of NMS, Hb was 10.5 g/dL; serum iron, 76 mg/dL; ferritin, 29.41 mg/dL; and sedimentation rate was 26 mm/h (Figure 1).

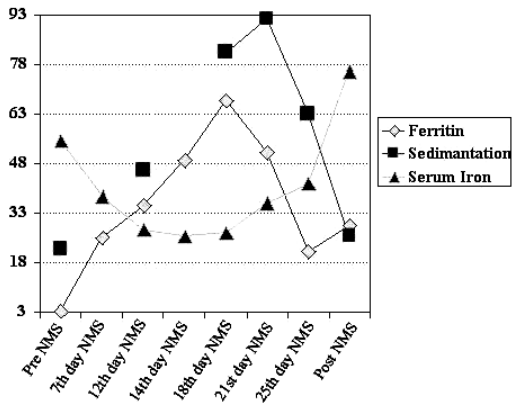

Figure 1. Changes observed in acute phase reactants during the course of neuroleptic malignant syndrome-NMS in a case with bipolar illness (ferritin, mg/dL; sedimentation, mm/h; serum iron, mg/dL).

Serial biochemistry findings in this case support the notion that NMS may represent an acute phase reaction [2,3]. The potential benefit of anti-inflammatory medications in NMS needs to be investigated.

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Olanzapine in anorexia nervosa

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Antipsychotic medications have been used in the treatment of anorexia nervosa since the 1960s and are prescribed for distressing obsessionality, anxiety, and psychotic-like thinking [1]. Recent case reports and open-label trials suggest that atypical antipsychotics such as olanzapine [2], risperidone [3,4] and amisulpride [5] may be beneficial in the specific treatment of anorexia nervosa.

We report the results of a retrospective case note analysis of 14 female patients aged 19–49 years with DSM-IV anorexia nervosa (57% restricting and 43% binge-eating/purging subtype) admitted to the Eating Disorders Unit at the Austin and Repatriation Medical Centre between 1996 and 2001, and who were prescribed olanzapine. Most had a chronic illness (average duration 10.46 years, SD 7.46) with significant psychiatric comorbidity. Six (43%) patients also had DSM-IV major depressive disorder, and their mean Hamilton Depression Rating Scale score was 27.2 (SD 4.9) before, and 23.7 (SD 6.8) after olanzapine prescribed concurrently with antidepressant medication. Two patients had DSM-IV borderline personality disorder, and one DSM-IV schizophrenia, paranoid type. Two patients had partially remitted substance abuse in addition to borderline personality disorder and major depressive disorder, respectively. The average body mass index (BMI) before olanzapine was 14.2 kg/m^2 (SD 1.9 kg/m^2) and post-olanzapine was 15.3 kg/m^2 (SD 1.2 kg/m^2) following an inpatient course. The comorbidity and low initial BMIs were indicative of selection biases inherent in this patient population. The improvement in BMI was clinically and statistically significant with olanzapine alone and in conjunction with other psychotropics (two tailed t-test: $p = 0.027$ and $p = 0.013$, respectively). Five patients had a drop in BMI (average 0.8 kg/m^2, SD 0.4 kg/m^2) not of clinical significance. Two of these had been prescribed olanzapine alone, two had comordid major depressive disorder and one, borderline personality disorder.

All 14 patients were prescribed olanzapine to diminish anxiety that was interfering with nutritional rehabilitation. Other indications included: overvalued ideation impacting on normalization of eating behaviours; facilitation of weight gain not effected with other treatments; comorbid psychotic phenomena; and dampening of excessive motor activity. The mean duration of inpatient olanzapine treatment was 24.9 days (SD 15.5). The mean inpatient dose was 9.7 mg/day (SD 5.7). Nine women (64%) and 11 of the total 18 admissions were prescribed olanzapine alone, whilst five (35%) were prescribed concurrent psychotropic medication including SSRIs (fluvoxamine, sertraline, paroxetine) SNRI (venlafaxine) and tetracyclic (mianserin) antidepressants. Two patients prescribed antidepressant medication had a subsequent course of electroconvulsive therapy. None of those readmitted were prescribed concurrent psychotropic medication.

This study explored the use of olanzapine in anorexia nervosa in a specialized unit and covered a period when this treatment was preliminary in nature. The study's limitations include: retrospective design; absence of a control group; small sample size; varying and ill-defined illness severity; heterogenous comorbidity; varying indications for olanzapine; and prescription of concurrent psychotropics. Further evaluation of the role of serotonin-dopamine antagonists in anorexia nervosa with controlled trials using defined outcome measures are required to determine whether there is specific benefit as opposed to the side-effect of weight gain countering the anorectic state, or weight gain secondary to anxiolysis or treatment of psychiatric comorbidity.

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The journal and drug advertising

***Jon Jureidini**, Department of Psychological Medicine, Women's and Children's Hospital, North Adelaide, Australia; **Peter Mansfield**, Director, Healthy Skepticism Inc:*

Radio interviews often do not provide time for deep reflection, and so we are writing to request that you reconsider what you said, in your role as Editor of this *Journal,* on Radio National's 'All in the Mind' programme on the 8th of December 2002. In that interview, you were challenged about the amount of advertising in this *Journal* and in particular the practice of encasing the journal with an ad. You responded: 'our doctors are not stupid, and they will simply rip the wrap-around and dispose of it . . . Nobody is gullible'. Did you intend to imply that this journal unethically exploits drug companies by billing them for advertising that is useless because all of your readers are infallible? We agree that your readers are intelligent. However, few of us have the advanced training in logic, statistics, advertising psychology, and evaluation of evidence or the time that critical appraisal of drug advertisements requires. Even if we did, there is no guarantee that critical appraisal skills would be enough to protect us from potential adverse influences acting outside of our awareness. Drug advertisements do not fool all of the doctors all of the time, but they are known to be effective enough on average to provide good return on investment [1] otherwise drug companies would not pay for them. Wrap advertisements are designed to work during the seconds it takes to pick up a journal and rip them off. The fact that they are usually not given much attention enhances their influence by getting the message into our brains under the radar of critical appraisal [2].

Because advertising is only profitable for new drugs and because new drugs are rarely better than the alternatives (including non-drug therapies) we believe that on average drug advertising does more harm than good. Acceptance of advertising inevitably undermines the journals' ability to be, and to be seen to be, independent. On the other hand we accept that advertising revenue can be used for benefit; advertising therefore raises important and complex ethical dilemmas. Your off-the-cuff attempt to explain away the problem is surprising and disappointing from someone with your level of sophistication in medical ethics [3]. We are concerned that rather than reassuring many members of the ABC radio audience, you may have fuelled unhealthy scepticism about psychiatry. Please reconsider.

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Editor's reply

Professor Sidney Bloch

May I assure Drs Jureidini and Mansfield that I take advertising in the Journal very seriously. My comments on the radio program to which they refer were certainly not 'off the cuff' but I did anticipate that my 45 minute taped discussion with the journalist would not necessarily be properly represented in a 30 minute program with several other contributors.

I do welcome the opportunity now to clarify the following points:

- I screen all advertisements both for content and style so that no misleading or offensive material is permitted (we have rejected several advertisements over the years);
- Advertising material is restricted to the front and back of the Journal; the editorial text is completely free of advertisements;
- I cannot possibly agree with the comment that '. . . new drugs are rarely better than the alternatives, including non-drug therapies'. This is absurd. It is indisputable that we have moved beyond chlorpromazine;
- I cannot agree either that advertising material undermines a journal's independence – as previously mentioned the advertising material is entirely separated from the editorial material;
- I would maintain that our readers have the capacity to evaluate advertisements or pursue any aspects about which they are uncertain;
- I do not claim 'any greater sophistication in medical ethics' than my colleagues, but I can state confidently that the Editorial Board including myself are constantly aware of the ethical dimensions of scientific publishing and regularly have it on our agenda.