

Hyponatraemia Masquerading as Malignant Neuroleptic Syndrome

SIR: We wish to report the case of a patient suffering from acute hyponatraemia with water overload presenting as malignant neuroleptic syndrome.

Case report: A 27-year-old male weighing 76 kg was admitted comatose with tremor, rigidity, pyrexia of 39°C, sinus tachycardia of 140/min, blood pressure 190/80 mmHg, urinary incontinence, and a right extensor plantar response within one day of receiving the eleventh fortnightly dose of clopenthixol decanoate (300 mg by injection) for schizophrenia. Malignant neuroleptic syndrome was tentatively diagnosed.

Laboratory investigations on admission were: white cell count $22.4 \times 10^9/\text{litre}$ (85% neutrophils); Na 116 mmol/litre; measured plasma osmolality 234 mOsm/kg; urea 3.3 mmol/litre and the osmolality of the 2.2 litres of urinary output in the first 4 hours of admission was 108 mOsm/kg. Creatine kinase was 873 i.u./litre (normal range <70), and bilirubin 33 $\mu\text{mol/litre}$ (normal range <17). Blood glucose and CSF examination was normal. A trace of salicylate only was found on screening for other drugs, and lithium was excluded.

Benztropine mesylate (2 mg) and normal saline (1 litre) were commenced. A rapid recovery ensued in the second 12 hours following admission, in association with a urine output of 7.2 litres in the first 24 hours. By the second day a mild degree of Parkinsonism was the only remaining sign, and the white cell count was $11.1 \times 10^9/\text{litre}$, Na 136 mmol/litre and bilirubin 21 $\mu\text{mol/litre}$.

The severe hyponatraemia with a calculated excess body water of 7.8 litres and the acute polyuria indicated that primary acute water intoxication was the key. The speedy recovery confirmed this. SIADH induced by a depot drug would have a much longer duration of effect. The raised total CK, pyrexia, and bilirubinaemia resulted from skeletal muscle hyperactivity, with some haemolysis and drug-induced cholestasis probably contributing to the bilirubinaemia. Pyrexia and varying neurological signs are features of acute severe water intoxication (Arieff & Guisado, 1976). Neutrophilia – almost certainly due to stress-related endogenous corticosteroids – pyrexia and autonomic instability are also features of the malignant neuroleptic syndrome (Abbott & Loizou, 1986). Thus plasma sodium is an important investigation in the diagnosis of malignant neuroleptic syndrome.

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AIDS-Phobia

SIR: Five male patients presented to us with psychiatric symptoms associated with the fear that they had AIDS. They were tested by the enzyme-linked immunosorbent assay technique and found to have no antibody to the causative virus infection of AIDS. The common features included: an anxious neurotic premorbid personality; tendency to have low extraversion and high neuroticism scores on the Eysenck Personality Questionnaire; a history of promiscuous heterosexual contact, and symptoms and signs of an anxiety state.

Reports from Western countries have documented a similar condition, under the name 'AIDS-panic' or 'pseudo-AIDS', with obsessive and paranoid features in the premorbid personality (Schwartz, 1983; O'Brien & Hassanyeh, 1985), and a history of homosexual contact and clinical features of anxiety or depression (O'Brien & Hassanyeh, 1985; Miller *et al.*, 1985). There are similarities and differences in these cross-cultural reports. Neurotic individuals appear to be more prone to develop AIDS-phobia in India than in the West. Both groups show neurotic reactions as a response to the fear. In the West a history of male homosexual exposure is usually present, as it is the predominant risk factor for AIDS. In India the infection has been found mainly among women prostitutes (Simoes *et al.*, 1987), and the public have been warned of the danger of promiscuous heterosexual contact. Although the terms 'AIDS-panic' and 'pseudo-AIDS' have been used for this condition, 'AIDS-phobia' may be a better name, since it is similar to venerophobia.

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Art Therapy

SIR: In his review of the book *Art Therapy for Groups* by M. Liebmann (*Journal*, December 1986, 149, 805), Aveline, in commenting on group dynamics, states: "This imbalance is worrying and reflects a deficiency in the training of art therapists". In fact, much emphasis is placed on group dynamics in the three postgraduate Diplomas in Art Therapy: at Hertfordshire College of Art, St Albans; Sheffield University; and Goldsmiths' College, University of London. I can speak more specifically about the Goldsmiths' course, where five out of eight of the tutors are qualified group psychotherapists as well as art therapists and the other three have extensive experience of group dynamics. Our course is structured around a model of art therapy combined with group analysis, and the students participate in weekly experimental groups, including one focusing solely on group dynamics. We do not neglect individual therapy, but are known for our 'group bias'.

The profession of art therapy is fairly new and is an easy target for misconceptions concerning training and practice. Full information about the courses can be obtained from each of the three centres, and general information on art therapy can be obtained

SIR: May I comment on Aveline's review of Liebman's book *Art Therapy for Groups: The Handbook of Games and Exercises*. While his criticism of the book's meagre psychodynamic content may be fair comment in the context of the powerful feelings that can be aroused by some of the exercises described, it is misleading to say that this a reflection of the "deficiency in the formal training of art therapists". On the contrary, the Postgraduate Diploma course in Art Therapy at Goldsmiths' College is firmly and extensively based on group dynamics, both theoretical and experiential.

The techniques described in the book demonstrate one approach to art therapy, which can perhaps also be used by other professionals wishing to use art in their work with patients. However, I think it is true to say that qualified art therapists have a deep concern and understanding of the emotional forces which may surface through the use of art, and are fully aware of the implications of individual and group dynamics.

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A HUNDRED YEARS AGO

Lunacy and Pauperism

At a recent Poor Law Conference in Glasgow, Dr Yellowlees read a highly interesting paper on the above theme. He urged that every county or district should have two types of asylums for its pauper insane; one a hospital, fully equipped with the best means of treatment, and receiving all new cases, the size not exceeding 300. Another building, erected at

half the cost, should be devoted to chronic cases only, and should receive no patients except from the cure-asylum.

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