

References

- GALLAGER, D. W., HENINGER, K. & HENINGER, G. (1986) Periodic benzodiazepine antagonist administration prevents benzodiazepine withdrawal symptoms in primates. *European Journal of Pharmacology*, **132**, 31–38.
- GOLOMBOK, S., HIGGITT, A., FONAGY, P., *et al* (1987) A follow-up study of patients treated for benzodiazepine dependence. *British Journal of Medical Psychology*, **60**, 141–149.
- GONSALVES, S. F. & GALLAGER, D. W. (1985) Spontaneous and Ro 15–1788-induced reversal of subsensitivity to GABA following chronic benzodiazepines. *European Journal of Pharmacology*, **110**, 163–170.
- HIGGITT, A., LADER, M. H. & FONAGY, P. (1985) Clinical management of benzodiazepine dependence. *British Medical Journal*, **291**, 688–690.
- MILLER, L. G., GREENBLATT, D. J., ROY, R. B., *et al* (1988) Chronic benzodiazepine administration. II. Discontinuation syndrome is associated with upregulation of γ -aminobutyric acid_A receptor complex binding and function. *Journal of Pharmacology and Experimental Therapeutics*, **246**, 177–182.
- WHITWAM, J. G. (1988) Flumazenil: a benzodiazepine antagonist. *British Medical Journal*, **297**, 999–1000.

Dystonia – a potential psychiatric pitfall

SIR: We welcome the article by D. G. Cunningham Owens (*Journal*, May 1990, **156**, 620–634) since it is most important for the psychiatric community to be familiar with the recent developments surrounding dystonia (Fahn *et al*, 1987; Marsden & Quinn, 1990). Recently, a 42-year-old woman admitted to our psychiatric unit with the diagnosis of conversion hysteria was, after a comprehensive evaluation (including computerised tomography, magnetic resonance imaging, and cerebral angiography), given the diagnosis of dystonia, secondary to an arteriovenous malformation occupying the right basal ganglia. The patient presented with flexion of the fourth and fifth fingers and sustained contraction of the left hand and forearm. She also complained of pain and stiffness in the affected area. Her condition had started five years before admission, while she was going through significant life stress, and during that period she sought the help of several neurologists, neurosurgeons, psychiatrists and orthopaedists. However, she was first seen by a neurologist who, considering her disorder primarily psychogenic, referred her to a psychiatrist.

We agree with the author's opinion that psychiatrists should be cautious in attributing any dystonic abnormality to a purely psychogenic causation. As our case shows, however, we would like to extend this advice to other clinicians, in particular neurologists.

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References

- FAHN, S., MARSDEN, C. D. & CALNE, D. (1987) Classification and investigation of dystonia. In *Movement Disorders* (eds C. D. Marsden & S. Fahn) London: Butterworth and Co.
- MARSDEN, C. D. & QUINN, N. P. (1990) The dystonias. *British Medical Journal*, **300**, 139–144.

Primitive reflexes in Alzheimer's disease

SIR: Girling & Berrios (*Journal*, December 1990, **157**, 888–893) report on an uncontrolled study of 146 elderly patients with clinical evidence of Alzheimer's disease and find a correlation between cognitive impairment, frontal lobe signs, including primitive reflexes, and extrapyramidal signs.

We have carried out a pilot study of 133 female patients above the age of 55 in a large psychiatric hospital in order to see if primitive reflexes were associated with cognitive impairment.

The mean age of our population was 78.6 years, similar to the psychiatric ward population of Girling & Berrios, which had a mean age of 80.0 years. We found the following frequencies of primitive reflexes: glabellar tap 81.2%, grasp reflex 52.6%, sucking reflex 30.8%, forced grasping 33%, palmomental reflex 23.3%, snout reflex 26.3%. These reflexes were found more frequently in patients with severe global dementia. When reflex frequency was plotted against age in the severely demented group, there appeared to be a bimodal distribution with a dip in frequency in the 75–79 age range.

These preliminary findings are compatible with those of Girling & Berrios and with the existence of two subtypes of Alzheimer's disease, as postulated by several authors.

However, the experiment should be replicated in a controlled study of a much larger population of patients with clinical evidence of Alzheimer's disease to minimise the possibility of an age effect.

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Panic attacks in schizophrenia

SIR: Argyle (*Journal*, September 1990, **157**, 430–433) studies the occurrence of regular panic attacks in 20 chronic schizophrenic patients, and finds seven cases, a far from negligible amount. The author also reports that neuroleptics may increase panic attacks in some psychotic patients.