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'Slowly progressive schizophrenia'

SIR: By criticising the concept of slowly progressive or sluggish schizophrenia adopted by Snezhnevsky and his school in the USSR, Shafran *et al* (*Journal*, August 1989, **155**, 174–177) reject not only the existence of this concept but also that of simple schizophrenia. The main support for the authors' idea comes from DSM–III. They point out that "Simple schizophrenia by name has disappeared from DSM–III–R", and that the concept of latent schizophrenia which appeared in DSM–II "was, of course, radically changed for DSM–III".

It is amazing that the authors do not even mention ICD–9 which is the internationally approved classification and which describes simple schizophrenia. In the preliminary version of ICD–10 (World Health Organization, 1987) it is included again under F21.1. Black & Boffeli (1989) suggest that it might even reappear in the next version of DSM. It should not be forgotten that the rejection of simple schizophrenia in DSM was due mainly to the overdiagnosis of this disorder in the USA. Even if a diagnosis can lead to mistakes, it does not mean that it does not exist.

An important argument used by Shafran against simple schizophrenia is Schneider's concept of the first-rank symptoms: "... the Schneiderian backlash put an end to his [Bleulers'] concept of schizophrenia". Although invaluable for the diagnosis and for research purposes, the importance of first-rank symptoms is clearly overestimated. It is worth remembering Schneider's (1950) own words: "... which we call first rank symptoms not because we regard them as 'basic disturbances' but because they have special significance for the *diagnosis* both against nonpsychotic mental abnormalities, as well as against cyclothymia.... Nothing is said about the theory of schizophrenia, unlike Bleuler's basic and accessory symptoms or the primary and secondary symptoms of other authors.... First rank symptoms do not have to be present for the diagnosis of schizophrenia ..."

Over-reliance on first-rank symptoms (and on positive symptoms as a whole) could lead to diagnosing only one form – paranoid schizophrenia. The characteristic 'negative' features of residual and simple schizophrenia, which are also prominent in the hebephrenic form, are at least as important in diagnosing and understanding schizophrenic illness. If more attention is paid to the variety of symptoms, some of them very subtle, more diagnostic entities will emerge. Not only Snezhnevsky has described many forms. Leonhard (1986), for instance, listed 19 subforms of schizophrenia apart from the three cycloid psychoses. Such efforts for greater diagnostic precision should not be discouraged, even if they make life more difficult.

Simple schizophrenia has the right to exist because here we see the basic symptoms which are more specific of the schizophrenic deterioration than anything else. They include the peculiar change in the personality which is not seen anywhere else in human pathology, namely that the person loses the core of their personality and is completely different in their reactions to important things in their surroundings. In this respect we could probably cite Ey *et al* (1974): "... schizophrenia is not at the beginning of the evolution but at its end".

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Temporal lobe atrophy versus open operculum in Asperger's syndrome

SIR: The report by Jones & Kerwin (*Journal*, April 1990, **156**, 570–572) concluded that the patient with Asperger syndrome had atrophy of the left temporal lobe. On the basis of the computerised tomography

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