a viral encephalitis, among other things, was suspected. A comprehensive neurological workup was negative, and the stupor resolved with time and supportive care. However, the patient was re-admitted at the age of 14 years to a psychiatric service under my care, clearly exhibiting signs of classic mania. During a prolonged hospital stay, the clinical state changed to a depressive stupor, resolving quickly with the use of electroconvulsive therapy. The patient eventually left hospital and was stable on lithium, although he had subsequent re-admissions in the following years. There was a strong family history for affective disorder. The results of the dexamethasone suppression test would have been interesting; however, the test had not been adapted for use in psychiatry as yet.

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Multiple Personality Disorder

SIR: Fahy's thorough review of the literature on multiple personality disorder (MPD) (*Journal*, November 1988, **153**, 597–606) reveals an ambivalence which makes us wonder whether the author has actually recognised and treated MPD cases. He acknowledges the fact that typical MPD symptoms such as psychogenic amnesia and alterations in behaviour, attitudes, and taste are presented before contact with a clinician is established and before hypnosis is used. He correctly criticises claims that MPD is an iatrogenic disorder. Yet, referring to the rise and fall of hysteria at the end of the 19th century, he downplays its existence as a separate syndrome. He states that supporters of the diagnosis point to the wide distribution of cases in time and place, but that this distribution no longer extends outside the USA.

Dr Fahy's historical review overlooked an important European source. A century ago, the French psychiatrist Pierre Janet conducted a series of careful clinical studies on hysteria (Janet, 1889, 1901, 1907). He regarded hysteria as a broad class of mental disorders which had a dissociative foundation in common, and were in many cases related to traumatic experiences. Hysteria included somatisation disorder, conversion disorder, psychogenic amnesia, psychogenic fugue, MPD, and certain other syndromes with predominant dissociative features. Characterising MPD as having distinct alter-personalities with their own sense of self and their own life history, and having different patterns of amnesia between these personalities, Janet clearly regarded MPD as a separate syndrome.

As Dutch clinicians working in a psychiatric outpatient clinic, we are currently treating 15 MPD patients, and in consultation and diagnostic interviews we have seen many more. In conformity with the findings of American research studies, all of these patients had a severely traumatised childhood, had been known to psychiatry for many years under widely divergent diagnoses, and had not benefited from conventional treatment approaches. In our experience, they generally respond favourably to MPD-specific treatment. MPD is clearly not an American disease, but our American collegues are worthy of our praise for refocusing attention on a disorder which has not had a fair chance in psychiatry.

We agree with Dr Fahy and others that DSM–III and DSM–III–R criteria for the diagnosis of MPD are vague, especially with regard to the definition of personality. Many of the patients to whom we would give the DSM–III–R diagnosis of 'dissociative disorder not otherwise specified' are perhaps seen as MPD cases in the USA. A more rigorous set of diagnostic criteria is urgently needed. Although MPD often coexists with other Axis I and Axis II disorders, we disagree with Dr Fahy's conclusion that MPD has arbitrarily become the primary diagnosis and that MPD symptoms do not justify a final diagnosis. The most important reason for giving the MPD diagnosis priority is that in otherwise intractable cases, apt treatment can be provided.

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Lofepramine-induced hyponatraemia

SIR: We would like to report a 74-year-old spinster who developed hyponatraemia while receiving lofepramine.

Psychotropic drugs were first implicated with the syndrome of inappropriate secretion of anti-diuretic hormone (SIADH) by Luzecky *et al* (1974) in a patient receiving amitriptyline. This has been noted on six subsequent occasions with this drug, and further reports of SIADH in patients receiving imipramine (2 reports), desipramine (3 reports), carbamazepine, clomipramine, nomifensine, dothiepin, and tranylcypromine have been published.

Case Report: This patient was admitted after a two-month history of manic-depressive psychosis – depressed type. She had been treated with amitriptyline (50 mg b.d.). There was a history of three previous episodes of depression which had responded to antidepressant medication or ECT.

On admission her sodium was 139 mEq/l. She was also noted to be anaemic, this being attributed to long-term therapy with ibuprofen. Her medication was changed to lofepramine (rising to 210 mg/day). No change was made to her other medication: atenolol (100 mg mane), lormetazepam (1 mg nocte), and ispaghula husk (Fybogel). Fifty days after starting on lofepramine the patient was noted to be becoming anorexic, weaker, and confused. Her sodium was noted to have dropped to 121 mEq/l. The serum osmolality dropped to 250 mOsm/kg (normal range 275–295), and the urine osmolality rose to 519. There was no evidence of intoxication. Physical examination was unremarkable. Chest X-ray and midstream specimen of urine was normal.

Fluids were restricted to 1 l/day, the lofepramine stopped, and trazodone commenced. Eventually the sodium returned to normal values (139 mEq/l), and the serum osmolality rose to 276 mOsm/kg. She later went on to respond well to a short course of ECT.

We feel that this patient fulfilled the criteria for a diagnosis of SIADH according to the criteria of Bartter & Schwartz (1967). She had hypo-tonicity of the serum, with a low sodium level and inappropriately elevated urine osmolality. The urine sodium and arginine-vasopressin were not measured. There was no clinical or biochemical evidence of cardiovascular, liver, renal, or adrenal disease, nor of dehydration. There was no report of recent head injury. Re-exposure of the patient to lofepramine was not done on the grounds of the patient's poor clinical condition. Hyponatraemia may occur acutely in psychiatric patients due to the psychosis itself (Rasking *et al*, 1975), secondary to compulsive water drinking (Chinn, 1974), or as a result of psychotropic medication.

The Committee on Safety of Medicines have received four reports of antidiuretic disorders possibly related to lofepramine. The manufacturers, E. Merck Limited (pers. comm.), have received two reports of hyponatraemia in patients receiving lofepramine. The first published report describing the possible association was by O'Sullivan & Oyebode (1987).

The effect noted is probably drug-specific to the patient and not to the drug class, as most reports show patients unaffected when treated with an alternative drug either before or after the implicated drug.

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Munchausen Syndrome Masquerading as AIDS-induced Depression

SIR: The psychiatric disorders associated with AIDS have been well documented (Fenton, 1987), and cover the breadth of psychiatric nosology. We describe a case of the Munchausen syndrome presenting with the fallacious claim that the patient had AIDS. To our knowledge this particular psychiatric association has not been previously reported.

Case Report: A 32-year-old unemployed seaman presented to the casualty department complaining of depressed mood, early morning waking, poor appetite, loss of concentration, weight loss, and a voice telling him to kill himself. He said these symptoms had begun when, a few months earlier, he had contracted pneumocystis carinae pneumonia and been informed that he was HIV positive as a result of his long-term intravenous drug abuse.

He was admitted to a psychiatric ward and gave a similar history, but with some differences in the timing of events. Suspicion was aroused when it was discovered that he was not known at the address he had given nor at hospitals to which he claimed to have been admitted. The hospital at which he claimed to have been diagnosed HIV positive refused to give any information as a matter of policy. The GP he had quoted had retired a year earlier and was untraceable.

The patient had a number of tattoos, and was eventually identified with the help of a merchant shipping company