In January 1985 we were contacted by journalists from *The Sunday Times* (20 January 1985) in connection with an investigation they were carrying out into the use of khat in Britain. They had found out that large quantities of the substance were being imported into London without restriction.

The Regional Drug Information Service informs us that no further cases have come to light in Liverpool, and it would appear that at present the use of the drug is mainly confined to certain ethnic communities. Possibly because of this it may be less likely to come to the attention of medical services.

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Reference

GOUGH, S. P. & COOKSON, I. B. (1984) Khat-induced schizophreniform psychosis in the UK. *The Lancet, i*, 455.

SIR: This case report (Critchlow & Siefert, *Journal*, February 1987, **150**, 247–249) does not accurately describe a typical case of khat psychosis. We reported three cases of catha (khat) psychosis (Dhadphale *et al*, 1981): our patients had paranoid psychosis with florid delusions which occurred in clear consciousness, and excessive use of khat was suspected as a possible causal agent. In a five year follow-up we did not find any relapse of psychosis in our subjects. Since then we have seen more than a dozen patients with khat psychosis, and all of them have shown a similar clinical picture as well as outcome.

As khat chewing is blamed for every social evil in our society by the lay press, our department has been involved in substantial research on various aspects of khat chewing (Omolo, 1985; Omolo & Dhadphale, 1987*a*). Our country grows and exports good quality khat leaves and a substantial number of our people in khat-growing areas chew khat for its amphetamine-like stimulant effect. Many use alcohol to counteract the sleeplessness which inevitably follows khat use (Omolo & Dhadphale, 1987*b*).

Critchlow & Seifert's case appears to us to be a mixed psychosis, probably toxic in origin, and due to several factors such as respiratory infection, possible morphine or dihydrocodeine use or abuse, or subtle malnutrition due to poor appetite and sleep deprivation – the latter two being the result of chewing khat. The authors should have inquired about the quantity of leaves chewed by the patient during the weeks prior to admission.

However, they have rightly alerted the medical and psychiatric communities in the UK to the possibility of khat being involved when a young person presents with a paranoid psychosis. Evidence of khat use may be found if the clinician examines the oral cavity of the patient for evidence of ulcers or stained teeth, which are common among habitual users.

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—— & DHADPHALE, M. (1987*a*) Prevalence of khat chewers among primary health clinic attenders in Kenya. *Acta Psychiatrica Scandinavica* (In press).

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Capgras' Syndrome in a Patient with Dementia

SIR: We report a patient who typifies some of the issues raised by Kumar (*Journal*, February 1987, **150**, 251).

Case report: A 79-year-old woman presented with a three-year history of the gradual onset of impaired memory. Two years after onset her husband was admitted to hospital for a few days for a minor operation. On his return he noticed that his wife made repeated references to her 'first' husband, whom she claimed had died some years before. She now referred to her husband as her second husband, despite acknowledging the very close resemblance in physical appearance, name, and profession between the two. Even though the husband could not convince her of his true identity, she showed no hostility towards him; as she said, "the new man is quite nice to be with". The husband's attempts to remind her of their earlier married life were always met with the reply: "but I was married to John in those days". At the time of presentation this belief had persisted unchanged for six months.

On examination, she had moderate impairment of memory for recent and remote events. She was mildly dysphasic and dyspraxic and could not name, or recognise as familiar, any of the subjects in a Famous Faces test. She did not score above chance level on a forced choice test of facial recognition. There was no evidence of depression or other abnormal beliefs, and her insight was limited to concern about her poor memory. CT brain scan revealed mild ventricular dilatation and sulcal widening but other investigations were normal, and a presumptive diagnosis of senile dementia of Alzheimer type was made.