acts to reduce the apparent incidence of schizophrenia, one would tend to increase, whilst the other diminish, the apparent incidence of other psychotic disorder.

The authors admit they are at a loss to offer a plausible mechanism for their interpretation, although they are evidently aware of its potential repercussions, especially in terms of the allocation of health services. In this regard, timely cuts from Occam's razor are less harmful than future cuts in already compromised services for the mentally ill.

SHÔN LEWIS

Institute of Psychiatry,
De Crespigny Park,
Denmark Hill,
London SE5 8AF

DE CLÉRAMBAULT'S SYNDROME—A NOSOLOGICAL ENTITY

Dr Ellis and Professor Mellsop's article (*Journal*, January 1985, **146**, 90–95) is a salutary exercise in diagnostic stringency. I would agree with them that it is likely that most cases described as erotomania are, in fact, suffering from a wider disorder such as schizophrenia, but I do not accept that the existence of primary erotomania can be summarily dismissed.

In my work on monosymptomatic hypochondriacal psychosis (MHP), I have encountered a similar situation. Many cases of delusional hypochondriasis prove to be secondary to other conditions, and when I began searching for primary cases I was told that they were excessively rare to the point of non-existence. Since there is now a growing literature apparently confirming the reality of the primary type, I am fairly satisfied that my recognition of it is not entirely delusional!

Several years ago, I was struck by the great similarity of the clinical picture in both MHP and pathological (paranoid) jealousy: the main difference lay in the delusional content. Again, paranoid jealousy may be seen in the "pure" or "primary" form, or may be secondary to other psychiatric illnesses. Two of my former residents and I have separately presented single case accounts in which primary paranoid jealousy responded well to pimozide, similarly to many cases of MHP (Dorian, 1979; Pollack, 1982; Munro, 1984).

More recently, after a long search, two colleagues and I identified two cases of primary erotomania, and successfully treated these with pimozide. Once more, the clinical picture is very like that of MHP, but this time the delusional content is one of erotic preoccupation. These patients are described in an article to be published by the *Canadian Journal of Psychiatry* (Munro, O'Brien & Ross, in press).

Cases of primary MHP, paranoid jealousy and erotomania fit very closely with Kraepelin's description of paranoia (Kraepelin, 1921). After his death, many psychiatrists denied that such a condition existed, but it has been rehabilitated and vindicated in recent years (Kendler, 1984) and I think that, until our present nosological system improves, we should place these three disorders under the rubric of paranoia. Incidentally, "primary" proves to be a relative term: I do my utmost to exclude cases with evidence of schizophrenia, affective disorder, organic brain disorder, obsessive-compulsive disorder, etc., but even so, I find that a history of substance and alcohol abuse (often non-current) is so common that I suspect that this may be an aetiological factor even in the primary presentation.

Dr Ellis and Professor Mellsop do us a service in encouraging us to be more careful in an area of diagnosis that remains tentative, but I do not accept as proven that cases of primary erotomania do not exist, although for the time being I shall accept that they seem rare.

ALISTAIR MUNRO

Dalhousie University,
Camp Hill Hospital,
1763 Robie Street,
Halifax, Nova Scotia

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THE PSYCHIATRIC INTENSIVE CARE UNIT

DEAR SIR,

I was interested in the article by Dr Goldney *et al* (*Journal*, January 1985, **146**, 50–54), describing a Psychiatric Intensive Care Unit in Adelaide, Australia, as I carried out a similar study of a new Psychiatric Intensive Care Unit at the North Wales Hospital, Denbigh, in 1982. The study looked at the admissions during the unit's first six months, using a questionnaire and microcomputer database. The