Self-poisoning

SIR: I take the point raised by Halasz (*Journal,* August 1987, **151,** 267) when he mentions my use of the word 'epidemic' in describing a rise in incidence of deliberate self-poisoning in the 1960s and early 1970s (*Journal,* May 1987, **150,** 609–614). I would, however, like to reduce any confusion that might arise from his letter by reminding readers that I was referring not to a suicide epidemic, but to a rise in the incidence of deliberate self-poisoning, the vast majority of instances of which are parasuicides, i.e. non-fatal acts.

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Late Paraphrenia

SIR: Grahame's letter about late paraphrenia (*Journal,* August 1987, **151,** 268) raises important issues which are dealt with rather too casually. Holden may, no doubt, wish to answer criticisms directed at his paper, but it is worth pointing out that he could not possibly have interviewed his patients using the Geriatric Mental State (GMS) since attentive reading of his text will show that the study was a retrospective one based on case notes.

Grahame appears unshakeable in his belief that late paraphrenia is merely a form of schizophrenia in old age because of the high proportion of cases with first rank symptoms in his sample. We would suggest that both the history of the concept and the results of more recent, systematic prospective studies using the Geriatric Mental State (Naguib & Levy, 1987) should lead to a more cautious approach to this perennial problem. As we have pointed out elsewhere (Levy & Naguib, 1985), the proportion of patients with first rank symptoms in our own larger and unselected group of patients studied prospectively was much lower (16 out of 43, compared with Grahame's 14 out of 25). Thus, even if one accepts the debatable proposition that first rank symptoms necessarily indicate schizophrenia, clinical evidence does not indicate a simple equivalence between late paraphrenia and schizophrenia of late onset. Furthermore, the evidence from HLA sub-typing points in the opposite direction (Naguib *et al,* 1987).

The role of organic factors, both as reflected by cognitive tests and by CT scan measures (Naguib & Levy, 1987), is also rather more complex than Grahame is prepared to concede. We have found minor cognitive changes and ventricular enlargement in a group of late paraphrenics, and follow-up 3.7 years later did not suggest that this was a harbinger of 'organic brain syndrome', as Grahame seems to believe, nor did it bear any obvious relationship to the clinical picture in the survivors (Hymas *et al,* in preparation).

The concept of late paraphrenia or persistant persecutory state in the elderly is one which is peculiarly robust. It is unfortunate that the draft of ICD–10 (World Health Organization, 1987), currently undergoing field trials, will, if accepted, mean that such patients will be distributed among at least four different sub-categories, thus making them somewhat difficult to identify. Nevertheless, identification should be possible, and we believe that the application of a variety of new techniques to the investigation of the problem should begin to clarify the nosological status of this entity or entities. In the meantime, it would be wise to keep an open mind about the question rather than to adopt unduly dogmatic attitudes towards it.

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Comparative Trial of a New Antidepressant

SIR: I strongly agree with Dunn's comments (*Journal,* August 1987, **151,** 269) on the study by Levine *et al* (Journal, May 1987, **150,** 653–655), comparing fluoxetine and imipramine.