was entitled to his 'share'. He was then distressed by his failure to achieve an erection. Since the couple's sex life has been in abeyance for years his wife made clear her fears for his physical health, which made him even angrier. He threatened her with a stick on a number of occasions. One night he tried to cut off her pyjamas with a pair of scissors, and this led to his referral.

His wife described a three-year gradual decline in memory. Premorbidly, he was said to be a self-contained suspicious man, particularly distrustful of women. There was no psychiatric history. Two months prior to the onset of this episode he suffered a chest infection during which he suspected his daughter of trying to poison him. These beliefs resolved completely following antibiotic treatment. On mental state examination, the features were delusional misidentification, delusions of jealousy, visual hallucinations, and impairment of short-term memory without impairment of consciousness. He had no insight, and expressed anger towards the "imposter". He was quite deaf, but otherwise physical examination was normal. Routine blood tests were normal. A diagnosis was made of a paranoid syndrome secondary to dementia, probably of Alzheimer type. He was treated with thioridazine, up to 100 mg/day, with resolution of the Capgras syndrome and visual hallucinations.

This patient is of interest for several reasons. Firstly, he illustrates Enoch's (1979) theory of ambivalence towards the loved object revealing itself in the Capgras syndrome, but differs in that the sexual demands followed the onset of the Capgras syndrome rather than that the rebuffed demands contributed to the development of the syndrome. One could speculate that a lesion in the right occipito-parietal area might result in both visual hallucinations and Capgras syndrome following the suggestion (Haymans & Abrams, 1977) that facial non-recognition causes the Capgras syndrome. However, I would agree with the observation (Weston & Whitlock, 1971) that the Capgras syndrome is the exact antithesis of facial non-recognition, there being no difficulty in the patient recognising the imposter as a replica of the person concerned. Sensory deprivation (Gluckman, 1968) has been mentioned as relevant; and this man's deafness, in conjunction with living close to a noisy girls' school, might be important aetiological factors.

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Trazodone-induced Mania

SIR: Knobler *et al* (*Journal*, December 1986, **149**, 787–789) report on three cases of trazodone-induced mania. Two of their patients had DSM–III mixed bipolar disorder, and the other had DSM–III recurrent major depression. I would like to report a case of trazodone-induced mania in a patient with a single episode of major depression.

Case report: A 58-year-old female widow met DSM–III criteria for major depression with melancholia (296.23) (single episode). She had suffered from depression for two years. Examination revealed depressed mood and affect, hopelessness, anhedonia, transient suicidal ideation, loss of energy and interests, loss of appetite and weight, and insomnia. She had no previous affective or other mental disorders. Her brother was a schizophrenic and committed suicide. Treatment (out-patient) with trazodone (50 mg t.i.d.) was started. In two or three days her mood was less depressed, and she felt better. But after one week of treatment, she became very talkative, quarrelsome, sleepless, hyperactive, and restless. She was spending money uncritically and frequently changed her clothes. She also thought that her grand-daughter had been poisoned by her son-in-law. She was admitted to hospital.

On admission she showed pressure of speech, psychomotor agitation, and mood-incongruent delusions. Trazodone was stopped, and treatment with haloperidol (1.5 mg t.i.d.) was started. After one day, her delusions completely disappeared and her mood was less elated. On the next day she was transferred to a general hospital because of paroxysmal tachycardia. There she was found to have hyperthyroidism and ischemic cardiomyopathy. She was seen after one month as an out-patient: her mood was stable and haloperidol treatment was stopped. After three weeks she was seen again, and she was in remission.

A causal connection between trazodone treatment and the manic state in this patient seems obvious. Her manic episode started only a week after trazodone was prescribed, and this was her first manic episode. She received trazodone without any other psychotropic medication. After the discontinuation of trazodone the manic episode remitted in less than ten days.

The mood-incongruent delusions in this patient are confusing. They were of short duration (about three days), but represent a difference between the patients described by Knobler *et al* and this patient. The patient's family history of schizophrenia may be relevant. The patient's hyperthyroidism could have

some aetio-pathogenetic role in the depressive episode, but this is less likely in the sudden mood change to mania. Our patient was probably hyperthyroid for more than one year (according to the medical history and findings). She had had no mood up-swings until the trazodone treatment began. If the manic state was triggered by hyperthyroidism one would have expected its manifestation earlier.

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Long-Term Psychiatric Patients In The Community

SIR: Kathleen Jones and her co-workers (*Journal*, November 1986, **149**, 537–540) paint an optimistic picture of care in the community in York when documenting the fate of 50 long-term psychiatric patients discharged into the community. They suggest that similar surveys in other areas might have less favourable results.

We conducted a follow-up of all patients who had been in Banstead Hospital continuously for at least 2 years and were subsequently discharged into the community between 1970 and 1981. There were 25 such patients.

The majority had led surprisingly stable lives since discharge (average 6.25 years). Readmission rates to hospital were low. All but one patient remained out of hospital, and only four others had been readmitted for brief periods. Half the patients had lapsed contact with the psychiatric services, but of these, half still had regular contact with their GPs and received depot medication. One patient was unfortunately in prison for aiding and abetting rape, and four had died of natural causes at an advanced age.

We assessed the quality of life of the patients by interview with the patients and their carers using a semi-structured interview. The patients fell into two groups of roughly equal numbers. The first group was made up of those with few if any symptoms, a low dependence on psychiatric services, and an ability to lead active independent and generally contented lives. These were primarily schizophrenic patients living in high quality group homes. The second group consisted of those with some degree of symptomatology, receiving a higher degree of support from psychiatric services and having a tendency to live more passive, dependent, and somewhat discontented lives.

Our findings support the view that community care with appropriate resources is a viable option for selected long-stay hospital patients.

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Erotomania and Cerebral Dysfunction

SIR: *Case report:* Recently a 30-year-old right-handed patient presented with erotomania of the de Clérambault's type and somatic delusions. Two years ago he met a 16-year-old salesgirl, felt it was love at first sight, and thereafter believed that she communicated a mutual love by means of silent gestures, ringing in his ears, telepathic messages, chain letters, and cars driving past him; he believed that she attempted to make him jealous by having sexual relationships with countless men. He had previously held similar beliefs about two other women. Over the same period he had somatic delusions, experiencing a number of physical symptoms that he attributed to the influence of this woman.

The patient had depressed mood and a large number of neuro-vegetative symptoms when these delusions were at their height, but had recovered by the time he was seen. He had made a suicide attempt in the past, had a history of heavy alcohol abuse ending four years previously, and had a family history of affective disorder. On examination he was mildly elated with rapid, pressured speech; verbal fluency was poor, he was unable to do an alternating hand sequence, and he showed verbal-motor dissociation on the right with the Luria hand sequence. The EEG showed left temporal abnormalities. The symptoms abated slightly with pimozide; the patient refused lithium and carbamazepine.

Erotomania has been reported with frontal and left temporal lobe dysfunction with secondary mania (Signer & Cummings, in press); the latter has shown a particular association with delusions (Sherwin *et al*, 1982). The EEG showed left temporal, and the cognitive examination left frontal, dysfunction. With appropriate examination and investigation more patients with erotic delusions may be shown to have organic abnormalities requiring specific treatment.

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