With regard to initial score on the Suicide Intent Scale, once again there was no significant difference between the attenders and non-attenders: Only 53% of patients with DSH rated as having been of serious intent came for out-patient follow-up. As to initial score on the HAMD, only 22% of those who scored 18 and over attended for follow-up.

On the Newcastle Depression Scale, 40% (five patients) of those with a diagnosis of endogenous depression attended (although the numbers were too small for any significance to be attached to them, compared to 39% with a diagnosis of neurotic depression—once again a non-significant difference between attenders and non-attenders.

Discussion

A working hypothesis which suggested itself to us before we commenced our study was that the patients who were more likely to be non-attenders would be those who were younger, who had a personality disorder, and who did not suffer a psychiatric illness. Our findings did not confirm this. On no major item investigated did we find clear-cut differences between those who attended and those who did not. A failure to attend applied equally to those with a psychiatric disorder, with clear symptoms of depression, and who had a high intent score, as it did to those without mental disorder or depression, or who had a low suicide intent score at initial interview.

Although we have not been able to identify the characteristics of those who failed to attend out-patients, our findings may well suggest that a different approach to the management of post-DSH patients may be required. Some patients may not see their problems in psychiatric terms (Kreitman, 1979), so that help from other professionals such as a social worker may be more appropriate—and this also suggests itself from the fact that most cases of DSH occur in the setting of social and interpersonal problems. Kreitman also suggested that attendance one week after the DSH may be too long for a patient to have to wait for help with his problems—an appointment within 2 or 3 days may therefore be more appropriate—and that seeing the patient away from the hospital setting, possibly at home, may improve the delivery of help offered to him. In this setting, the skills of a social worker or a community psychiatric nurse may be usefully applied, and such an approach would also be useful for a number of patients the psychiatrist would have wished to see at his clinic, but who default on this attendance. However, the early involvement of the general practitioner for the latter would also be valuable, more especially for the elderly depressive who may be at greater risk of suicide (Stengel, 1970). For the latter, the general practitioner and psychiatrist should liaise closely, in the event of the patient requiring either admission or a psychiatric domiciliary visit.

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G. O'Brien, MB, BS, *Registrar*; A. R. Holton, MB, BS, MRCPsych, *Senior Registrar, Nottingham University*; K. Hurren, MB, BS, MRCPsych, *Registrar*; L. Watt, MB, BS, MRCPsych, *Senior Registrar*; *F. Hassanyeh, MB, BS, MRCPsych, *Consultant Psychiatrist*, Royal Victoria Infirmary

*Correspondence: *Department of Psychiatry, Royal Victoria Infirmary, Newcastle upon Tyne, NE1 4LP*

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Khat-induced Paranoid Psychosis

For many hundreds of years the fresh leaves of the Khat shrub have been used for their stimulant properties. Several million people in East Africa and Arab countries chew the fresh leaves and with the growth of rapid air transportation the habit has spread.

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Cathinone is considered the most active ingredient and has been recently isolated and synthesised (United Nations Document, 1975). The effects of cathinone closely resemble those of amphetamine (Halbach, 1972), to which it is chemically related. Regarding the beneficial effects of Khat, Carothers wrote in 1945:

> The chewing of this weed induces a happy and mellow friendliness and an increased intellectual vigour and acuity, thought tends to rise to a high plane, desire for war and women ceases, and conversation tends to concern itself with 'the affairs of God' and the accumulation of wealth by peaceful trade.

Amphetamine like sympathomimetic stimulation occurs with elevated blood pressure, mydriasis, hyperthemia, anorexia, insomnia, increased arousal, elevated mood and loquacity (Halbach, 1972).

Khat abuse may cause psychic dependence (Eddy *et al*, 1965), aggressive behaviour, paranoid ideation and ultimately personality disorders (Kalix, 1984). It may cause manic psychosis (Carothers, 1945; Laurent, 1962; Giannini & Castellani, 1982), similar in many features to that which may be induced by amphetamines. A North Africán student, in the United States developed a manic psychosis following ingestion of Khat which he had grown in his own apartment (Giannini & Castellani, 1982).

Case Report

F. K. a 34-year-old Somali woman was admitted to a medical ward following an overdose of propranolol, paracetamol and choroquine. She is a part-time student, separated from her husband and two children since 1978, who lives alone in a Council flat. She had no significant past medical history and there was no history of past psychiatric illness either in herself or in her family.

When seen on the medical ward she was noted to have paranoid delusions and evidence of thought broadcast which took the following form. Over several weeks prior to admission she had felt convinced that there were microphones located on the stairway leading to her flat which were repeating her thoughts. She felt she was being watched and followed and a searchlight was focussed on her flat monitoring her activities. She reported that the television repeated her thoughts. During these weeks she was chewing Khat every day and on the day of admission had chewed it for 8 hours. Prior to admission she had noted a loss of appetite and said she had not slept for 48 hours. She had felt that everything built up inside her to such an extent that she took the overdose.

At this stage insight was completely lacking, and she was still actively suicidal, but her mental state was otherwise normal. She was noted to have a mild otitis media which was treated with antibiotics. Full blood count was normal, a chest X-ray showed evidence of a little right basal shadowing and atelectasis consistent with infection, and a urine drug screen taken 9 days post-admission showed evidence of morphine and dihydrocodeine. From the second day she was prescribed trifluoperazine 5 mg three times daily which she took regularly for 5 days and intermittently thereafter. She remained severely paranoid for 11 days after admission but on day 12 her mental state had reverted to normal and she was discharged shortly afterwards. We felt it probable that the trifluoperazine had been a contributory factor in her recovery.

She returned to be seen on the ward 3 weeks after discharge bringing a sample of Khat which was identified by the Regional Poisons Unit. Her mental state was quite normal at that stage.

On a recent visit she admitted to having used Khat on occasions since her admission 4 months ago. She still felt at times her activities were being monitored and felt there were possibly microphones on the stairway. However, she described that when she chewed Khat these feelings intensified and on enquiry, were found to be fully delusional. Indeed, after taking Khat on two occasions since discharge she has again felt like taking an overdose.

Discussion

We were unable to fully explain the positive urine test for morphine and dihydrocodeine. The urine test may remain positive for up to 4 days following ingestion, which would indicate she may have taken these substances while on the ward. She adamantly denied use of these substances and was not prescribed any compound containing them.

The case of F. K. serves to highlight the importance of knowledge of Khat use in the United Kingdom. Use of Khat has serious socio-economic consequences in that Khat users harm their families by neglect, dissipation of family income and by their inappropriate behaviour (Kalix, 1984). It may cause a functional psychosis following consumption of exceptionally potent material or in predisposed persons (Kalix, 1984).

Finally, although this is the first case known to the Regional Poisons Unit, it is likely that greater awareness of the problem may result in other cases coming to light. It is the impression of F. K. that extremely large numbers of the Somali community in London (approximately 4000) use Khat and this is likely to represent only a proportion of the problem. In the case of F. K. Khat appears to have induced a full-blown paranoid psychosis with the added complication of a suicide attempt.

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*Stephen Critchlow, MB, DCH, *Registrar in Psychiatry*; Ruth Seifert, MRCPsych, *Consultant Psychiatrist, Hackney Hospital*

*Correspondence: *Hackney Hospital, Homerton High Street, London E9 6BE*

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Down's Syndrome with Mania

Sovner *et al* (1985) proposed that the presence of Down's Syndrome (DS) precludes the possibility of concomitant mania, and this is not a new claim, since Earl (1961) had stated that neither cyclothymia nor manic-depressive psychosis occurred in the mentally retarded. While Sovner *et al* conceded that cases of mania in individuals with DS may simply have gone unrecognised or unpublished, they felt this to be unlikely. However, lest this suggestion enter the canon, we present a previously unreported case of a young adult with both DS and recurrent mania.

Case report

A moderately mentally retarded, 23-year-old man was brought to a university psychiatric clinic by his mother because she was concerned about his increasing activity, increasingly grandiose ideas and decreased sleep. Down's Syndrome had been previously diagnosed on the basis of physical stigmata at examination, as well as trisomy 21 on chromosomal analysis. There was no family history of psychiatric illness. The patient had had a similar episode 2 years previously, characterised by increased hyperactivity, increased rate and volume of speech, and decreased appetite and sleep. Thioridazine treatment was instituted at that time, following which the patient became somewhat sedated; the symptoms had remitted within a month.

Two months before the most recent referral, the patient had once again shown increasing levels of activity and impulsivity and his mother had been forced to restrict him to the home because he had wandered off and almost got lost. His deteriorating behaviour was accompanied by a preoccupation with grandiose delusions, including that of his becoming a famous musician. He also became increasingly irritable, particularly when his grandiose ideas were challenged. Physiological changes included decreased appetite, a weight loss of 9 kg (20 lb), and decreased sleep. On each of the two nights immediately before being seen, he slept at most 2–3 hours, and was reportedly dancing and singing when awake, although it was in the middle of the night.

When seen, the patient was dressed like a certain pop singer, and demanded to be called by that singer's name, stating that the examiner was a television producer interviewing him for a job. The patient's affect was characterised by rapid swings from elation to irritation, when his mother did not respond to his grandiose statements, but when not challenged, he was most engaging. The examination revealed no evidence of hallucinations or mood-incongruent delusions. The physical, neurological, and laboratory examinations were all within normal limits, while a cardiology consultation revealed no change in the patient's asymptomatic ventricular septal defect with intraventricular and intra-atrial conduction defects.

The diagnosis was made of bipolar affective disorder, manic with mood-congruent psychotic features (DSM-III). This diagnosis was later confirmed independently by two attending psychiatrists.

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