Letters to the Editor

Diagnosis and Serendipity

TO THE EDITOR: A discipline is "a body of theory and technique that must be studied and mastered to be put into practice" (1). Playing the piano, using a computer, and making psychiatric diagnoses are all disciplines. "To practice a discipline is to be a lifelong learner. You 'never arrive'; you spend your life mastering disciplines. You can never say . . . 'I am an enlightened person.' The more you learn, the more acutely aware you become of your ignorance" (1).

And so we study our discipline of making psychiatric diagnoses continuously, starting as residents and continuing as practitioners. We read books and journals, consult with others, attend conferences, and work with our patients.

Sometimes our learning takes another form—we read a book or poem, see a play or film, visit a museum, talk with others—and serendipitously we amplify our discipline. Recently I read a medical biography of Vincent van Gogh (2), and what I learned about his illness provided me with critical knowledge for understanding a perplexing patient.

> Mr. A was a man in his 40s who was admitted to the inpatient service. I knew that his diagnosis and treatment would be difficult because in the past 10 years, he had had a dozen hospitalizations—six for medical or surgical and six for psychiatric problems—at three medical schools and one research institute. His psychiatric diagnoses included schizophrenia, depression, bipolar disorder, and brain disorder. When I asked him about his chief complaints, he mentioned hallucinations (both auditory and visual), confusion with memory loss, and frequent episodes of severe abdominal pain. As I learned of this group of symptoms during the first moments of the interview, I had the shock of recognition that they were the same symptoms that van Gogh had had at his first hospitalization.
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> After completing the initial assessment, I ordered a specific urine test to investigate the disease I suspected. In Arles, France, in 1888, this test was not available to van Gogh's physician, Dr. Félix Rey. I told a colleague about my diagnostic hypothesis and predicted a 1% probability that it would be confirmed. Later, I was 99% amazed to learn that Mr. A's uroporphyrin level was abnormally high, which indicated the likelihood of acute intermittent porphyria, the disease that van Gogh allegedly had over 100 years ago (2). Mr. A's uroporphyrin level was still high 2 months later. Fortunately, appropriate treatment produced a remission of both physical and psychiatric symptoms.

How had I diagnosed acute intermittent porphyria, which has a prevalence of 5–10/100,000? It was serendipity. I had recently read about it and had it in mind. An ancient medical aphorism states that you cannot make a diagnosis if you do not know the disease exists. I was fortunate to know and remember it because of interests outside psychiatry.

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Why Is Dissociative Identity Disorder Infrequent in France?

TO THE EDITOR: As has been established by many studies, including in the *Journal* (1), dissociation and trauma are closely linked. There is an impressive body of evidence in American studies for this link (2). However, the diagnosis of dissociative identity disorder is very seldom made in France. We have formulated the hypothesis that this infrequency could be explained by the avoidance of the care system, especially the psychiatric care system, by victims of psychological trauma. We undertook a study of a population exposed to severe trauma (intrafamily rape) in order to look systematically for dissociative identity disorder.

We studied 30 victims of intrafamily rape who were over the age of 12. These victims were consecutive admissions to a forensic center for sexual violence; most were sent by a court order. This center is located in the Department of Gynecology at the University Hospital of Tours, France. The victims were interviewed by a psychiatrist who used the Structured Clinical Interview for DSM-IV Dissociative Disorders (3) and a questionnaire specifically constructed for this study that related sociodemographic and clinical data. Written informed consent was obtained from all subjects.

The mean age of the victims at the time of the interview was 17 years (range=12–24), and the group consisted of two male and 28 female subjects. Twenty-three (77%) were pupils or students, and seven (23%) had a job or were looking for a job. The fathers of 67% (N=20) of the victims were workers or office workers, and the rest of the fathers were from a higher social category. The victims' mean age at the time of the first rape was 11 years (range=5–19). The first assault had occurred a mean of 6.3 years earlier (range=5–15). For 87% (N=26) of the victims the rapes were repeated, and for 80% (N=24), they were repeated over more than 1 month. Physical violence (expressed violence, threat with a weapon or an object, the threat of being hit) occurred during the rapes of 37% (N=11) of the victims. This proportion shows that incest occurs frequently without any added physical violence. The mean difference in age between the victim and the perpetrator was 22.5 years (range=4–56). The rapes were perpetrated by the father (30%, N=9), the stepfather (27%, N=8), an uncle (27%, N=8), a brother (10%, N=3), or a grandfather (7%, N=2). Ninety percent (N=27) of the victims complained to the authorities. The group prevalence of dissociative disorders was 87% (N=26), and 14% (N=4) had dissociative identity disorder.

One could say that incestuous rape is not a common occurrence and that four cases of dissociative identity disorder out of 30 is not a large proportion. However, it must at least be said that this ongoing study should convince French psychiatrists that dissociative identity disorder can be found if looked for in appropriate populations. Moreover, the populations at risk for dissociative disorders are not so rare, since more than 100 people each year seek rape counseling at this forensic center in this town of approximately 200,000 inhabitants.

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Sertraline for Chronic Obstructive Pulmonary Disease and Comorbid Anxiety and Mood Disorders

TO THE EDITOR: A series of respiratory abnormalities have been identified in panic disorder patients (1). In fact, a high proportion of panic disorder patients suffer from chronic obstructive pulmonary disease (2). Conversely, the prevalence of panic disorder has been shown to be higher in patients with chronic obstructive pulmonary disease (3), and thus the degree of dyspnea in these patients is frequently greater than that expected from the severity of lung function impairment. Comorbid chronic obstructive pulmonary disease in panic disorder subjects frequently presents a treatment dilemma. Anxiolytics such as benzodiazepines have limited utility because they decrease respiratory drive and may compromise lung functions.

In view of the availability of a new class of antipanic drugs with little probability of respiratory depression, we have undertaken a pilot study to investigate the value of using sertraline for patients with chronic obstructive pulmonary disease with and without comorbid anxiety and mood disorders. Six consecutive patients with chronic obstructive pulmonary disease were recruited from an outpatient pulmonary clinic. They underwent a standard psychiatric interview and a routine spirometric evaluation. Arterial blood gas levels were also obtained. All subjects signed informed consent forms. One patient was diagnosed with simple phobia and dysphoria, one patient had panic disorder with agoraphobia, and a third patient had panic disorder and a major depressive episode.

A regimen of sertraline, 12.5 mg/day, was initiated and gradually increased to 100 mg/day over the next 2 weeks. Subjects remained at the same dose level through week 6, after which we reevaluated their spirometric results, arterial blood gas levels, and psychiatric status.

All patients tolerated the medication well and experienced minimal side effects. At week 6 five of the six patients showed improvement on a scale of daily living activity (4), and all subjects reported a general sense of well-being. The three patients with psychiatric diagnoses reported marked subjective improvement. There were no significant changes in spirometric indices or arterial blood gas levels.

The absence of harm and subjective benefits in this small group should encourage further testing of the efficacy and safety of sertraline. In the meantime, our preliminary conclusion is that the presence of clinically stable chronic obstructive pulmonary disease is not a contraindication to the use of sertraline for the treatment of panic disorder.

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Olfactory Function in Winter Seasonal Affective Disorder

TO THE EDITOR: Olfactory function may be of importance to the pathophysiology of winter seasonal affective disorder (1). Olfactory function has been shown in rodent models to affect photoperiodic sensitivity (2) and appetite (3), and affective vulnerability during the shortest days of the year and hyperphagia are characteristic symptoms of seasonal affective disorder. The few studies of olfactory function in major depressive disorder have yielded inconsistent results (4). To explore the possibility of an olfactory connection, we compared olfactory function in patients with seasonal affective disorder and normal volunteers.

During the winter we administered the University of Pennsylvania Smell Identification Test (5), a standard screening test for the capacity to identify 40 unique odors, to 21 medication-free depressed patients with seasonal affective disorder and 21 age- and gender-matched normal comparison subjects. All subjects provided written informed consent. The patient group had a mean age of 38 years (SD=9) and comprised 16 women and five men. Their mean depression score, as measured by the Structured Interview Guide for the Hamilton Depression Rating Scale—Seasonal Affective Disorders Version (6), was 29 (SD=6). The comparison subjects also had a mean age of 38 years (SD=9). Of the 14 premenopausal women in each group, 10 were studied in the same phase of the menstrual cycle as their match.

The mean score on the University of Pennsylvania Smell Identification Test (maximum possible score=40) was 38 (SD=1) for the patient group and 37 (SD=2) for the comparison group (paired $t=0.69$, $df=20$, $p=0.50$). The power to detect a mean between-group difference of at least two points when alpha=0.05 was greater than 97%.