PREMENSTRUAL SYNDROME

DEAR SIR,

The paper by Dr Gwyneth Sampson (September, 1979, **135**, 209–15) bears a title which is not only misleading but quite incorrect, it should be, 'Menstrual Distress: a double-blind controlled trial of Progesterone and Placebo'. No evidence is presented to show whether the patients in this trial were suffering from premenstrual syndrome. They were suffering from undifferentiated menstrual distress, as shown by the answers to their Moos Menstrual Distress Questionnaires. The diagnosis of premenstrual syndrome is quite simple for, by definition, it requires the presence of symptoms always in the same phase of every menstrual cycle, together with a complete absence of symptoms for a bare minimum of seven consecutive days during the postmenstruum, although most patients have at least 14 days without symptoms. Fig 1 of Dr Sampson's paper shows that there was no period of complete absence of symptoms in either the first or second month before treatment started.

The Moos Menstrual Distress Questionnaire is a valuable tool for assessing quantitatively the amount of menstrual distress, and this is improved by using Sampson and Jenner's sine wave modification, but it is not a diagnostic tool. It only measures menstrual distress, which includes, for example, spasmodic dysmenorrhoea and endometriosis as well as premenstrual exacerbation of endogenous depression, headache and backache.

Progesterone is the specific treatment for premenstrual syndrome, but it may increase symptoms of spasmodic dysmenorrhoea and endometriosis. This controlled trial has merely shown that progesterone suppositories have no value in the treatment of undifferentiated menstrual distress.

This paper also includes a curious heterogenous group of 19 women of whom 14 women 'considered they had premenstrual syndrome but had not sought treatment for it'. No information is provided about the other five control women. Did they suffer from menstrual distress, or was their menstruation free from symptoms? Experience at the Premenstrual Syndrome Clinic at University College Hospital, London suggests that only about half of the self-diagnosed women really have premenstrual syndrome as a single entity (with the complete absence of symptoms in the postmenstruum). It is only the accurately diagnosed premenstrual syndrome which responds successfully to progesterone.

KATHARINA DALTON

University College Hospital,
Gower Street,
London WC1E 6AU

VISUAL HALLUCINATIONS IN EYE DISEASE

DEAR SIR,

In an interesting paper (*Journal*, 1980, **136**, 284–286) Dr White discusses the visual hallucinations which might occur in patients with eye diseases. It is suggested that these hallucinations arise in the visual association areas, as these areas have been supersensitized due to the reduced visual stimulation.

We have treated a patient with eye disease and visual hallucinations, but suggest in this case a somewhat different pathogenesis.

The patient was a man of 72, who had been an art dealer, but had retired because of his eye disease. There was no history of head injuries or infections of the central nervous system, nor of abuse of alcohol or drugs. The patient described himself as being imaginative, emotional, and sensitive, but without psychiatric symptoms. From childhood he had had an excessive myopia. At the age of 58 he underwent surgery for retinal detachment on the left eye, the result achieving an acceptable acuity. During the last years he had impaired vision in the right eye, acuity being assessed as: right eye 1/24, left eye 6/12, with his own glasses. Ophthalmoscopy showed myopic degenerations bilaterally, especially on the right side. Neurological examination, EEG, X-ray of the skull and various clinico-chemical variables were normal.

For some weeks he had suffered from very vivid visual hallucinations. They appeared as soon as he closed both eyes, or the left eye (the eye with an acceptable acuity), but *not* when he closed the (nearly blind) right eye. The hallucinations started somewhere in the visual field with some unstructured black lines on a white background, eventually changing to formed figures, often animals in a landscape. The hallucinations were coloured and with shadows; they could be frightening with, e.g. fighting crocodiles or large lions. They immediately disappeared when he opened the eyes. He completely realized the unreality of the phenomena and he had no other neuropsychiatric symptoms. A large battery of psychological tests revealed no signs of localized cerebral lesion, but a slight to moderate general intellectual impairment—corresponding with his age. It was interesting that he found the Rorschach cards to be very similar to what he 'saw' immediately after he had closed his eyes.

We have now followed the patient for several years. In periods his visual hallucinations have been very troublesome, and it has for example been difficult for him to fall asleep because of the hallucinations. Small doses of neuroleptics, e.g. haloperidol, 2–4 mg a day, have helped more than sedatives.

His eye disease undoubtedly caused him to experience some unstructured visual phenomena ('phosfenes'). Pathogenetically we hypothesize that this imaginative and sensitive man, who had been occupied with art his whole life, converted these

https://doi.org/10.1192/bjp.137.2.199a Published online by Cambridge University Press