Findings

The presence or absence of false teeth was assessed in 159 patients. Over half of the patients had false teeth and their presence was associated with an increased age and later age of onset of the dementia. Patients with false teeth were less cognitively impaired, had more temporal lobe atrophy on CT scan and there was a trend for them to more often have a family history of dementia. The examination for false teeth was found acceptable to patients and no ethical problems were encountered. Several patients had two sets of false teeth, but these were only counted once.

Discussion

To our knowledge, this is the first study to investigate the presence or absence of false teeth in a neuropsychiatric disorder. The older age of the patients with dentures and their lesser degree of cognitive impairment may suggest a subtype of AD based on the presence or absence of false teeth. The trend towards an increased family history of dementia in patients with false teeth suggests a genetic predisposition to both, although this finding did not quite reach statistical significance despite great efforts by the authors. The association between the presence of false teeth and temporal lobe atrophy on CT scan may be as a result of reduced mastication leading to disuse atrophy of the limbic system.

Further studies (including case control studies) are essential, particularly on the effects of fluoridation of the local water supply and whether the acquisition of false teeth is before or after the onset of dementia. It may be that future research into AD should be directed more towards the mouth than the brain.

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Conference briefings

Mental health and deafness*

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The multidisciplinary conference took as its theme the potential for a British society for mental health and deafness which would be aligned with the European Society for Mental Health and Deafness (ESMHD). The ESMHD itself has encouraged new developments in Germany and Holland, providing information and support as well as the opportunity to learn from the mistakes and successes of established services in other countries. A major task is to promote the involvement and training of deaf people themselves, because, for profound, prelingual deafness, this population has all the hallmarks of a cultural and linguistic minority.

**Conference held on 15 November 1991 at St George's Hospital Medical School, London.*

The social model of health has particular relevance given that deaf people are often frustrated in their dealings with the hearing world. Specialist social workers with deaf people, with knowledge, awareness and communication skills are thin on the ground; trained, deaf social workers rarer still. They end up giving psychiatric opinions to generic health workers, because, for example, general practitioners have few of the appropriate skills and knowledge to make a proper assessment: the deaf person is often marginalised by this process.

The question 'Communication: disorder, deprivation or discrimination' was raised by Ms Alice Thacker, a Mental Health Foundation research fellow. Many deaf people with mental health

problems (including mental illness specifically) have communication problems stemming from each of these factors: cortical damage; developmental isolation; and unenlightened educational methods. Psycho-linguistic studies of formal thought disorder in deaf people with schizophrenia (often misdiagnosed in this group) are in progress. The first consultant post in Britain in the psychiatry of deaf children and adolescents has recently been established at Springfield and St George's Hospitals. There must be close links between parents, teachers, educational psychologists and doctors to recognise early and minimise the particular developmental difficulties experienced by deaf children.

Towards the end of the day a panel of researchers emphasised the need for ongoing work in this specialised field.

(a) Contrary to a generally held notion, a community survey appears to have found high levels of unrecognised depressive illness in prelingually deaf adults, using an adaptation of an established two-stage paradigm.
(b) The usefulness of certain phenomenological criteria for the diagnosis of schizophrenia has been re-evaluated.
(c) The communication and cultural divide between deaf and hearing people is likely to lead to under-reporting of mental disorder and misdiagnosis.
(d) Questionnaires can help teachers assess the emotional development of their deaf pupils.

The research development manager at the Royal National Institute for the Deaf, Dr Katia Herbst, announced the establishment of a directory of researchers and projects. A plea was made on behalf of those with later onset, acquired deafness, and hard of hearing people.

A decision was taken to set up a small steering party to discuss the constitution of a British Society for Mental Health and Deafness. Such a society would promote British experience in the field and encourage co-ordinated service developments and research.

Note

Proceedings of this conference are available (£5 as a text, £10 on videotape with sign language) from the Deaf Unit at Springfield Hospital, telephone 081-784-2773 (voice) or 081-784-2705 (Minicom).

Epilepsy and learning disability*

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Epilepsy is rife in learning disability and is a major component of any practice: it was chosen as the theme for the annual residential conference of the Mental Handicap Section. Its importance in everyday practice was affirmed by presentations from Ulster and Avon which examined the local prevalence of epilepsy in Down's syndrome. In both, the age of seizure onset had a bimodal distribution, the second peak occurring in the fourth decade. The growth of this group promises an increasing demand on overstretched services.

The scene was set by a series of ten-minute presentations of audit projects which summarised the clinical practice of five services and set some initial criteria for national comparison. There was an adherence to monotherapy, even with the intractable epilepsies; a bias towards carbamazepine and valproate with an avoidance of phenytoin and barbiturates; an annual review including drug levels and liver function; and repeated questioning of the amount and type of medication. The subsequent discussion brought out the difficulty of establishing a reliable fit chart, the lack of an agreed threshold for the use of rectal medication in status epilepticus, and the need to take the overall quality of the patient's life into account. Furthermore the models of audit marked a methodological path for others to follow.

Expert reviews of the modern management of epilepsy filled the following day. The association between epilepsy and psychiatric disturbance was emphasised, of some importance in a field where it is the fashion to replace the psychiatrist with the neurologist (Steven Brown). Immediately relevant to psychiatry was the potential for the psychological control of seizures (Peter Fenwick), and the misdiagnosis of stimulated seizures as epilepsy (Tim Betts). The role of two new drugs was defined further in discussion; lamotrigine for the treatment of myoclonic phenomena and vigabatrin for complex partial seizures. Although at present these are limited to use as an add-on drug in intractable epilepsy, there was optimism for their potential as 'clean' and

**A joint conference between the Section for the Psychiatry of Mental Handicap and the International League against Epilepsy, Jersey, 21–23 November 1991.*

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