drugs other than benzodiazepines for night sedation had been prescribed for her since early 1973. We agreed to her request. In February 1978 she was asked to reduce her dose of lithium of 1200 mg/day by 400 mg at intervals of three weeks and then to stop treatment. In April, two weeks after stopping lithium, her husband reported that she had become unwell. She was found to be mildly confused and anxious but not depressed or excited. We thought that her condition might be a lithium withdrawal effect, so lithium was restarted at a dose of 400 mg/day. After 10 days she had improved, so lithium again was stopped. After two days she relapsed and was admitted to hospital. She was unkempt and her fluctuating mental state was characterised by mild impairment of consciousness, brief lucid intervals, restlessness, perplexity, incoherent speech, and labile mood. Assessment of cognition was impossible because she was distractible and inattentive. The clinical picture resembled an acute toxic confusional state, but physical examination and investigations showed no abnormality. Lithium was restarted at a dose of 1200 mg/day. A fortnight later her mental state was normal but she remained amnesic for the period of the acute illness. Psychological tests done just before discharge showed her to have average intelligence with no areas of cognitive impairment.

Comment

Adverse reactions to psychotropic drug withdrawal are well known,³ but an acute psychosis, with the features of this case, has not been reported after withdrawal of lithium. We found no other cause for our patient's illness. The link between it and stopping lithium is inferred. She returned to her former state of health when lithium was restarted, and remains well taking the drug.

General principles and the risks of permanent damage from lithium side effects suggest that its use in each case should be reviewed regularly. When deciding to stop lithium prophylaxis consideration should be given to when and how to do it. From our experience we think that lithium might be best withdrawn slowly over some months. Since some patients resist when advised that it is in their interest to stop taking lithium it might be better if they were told initially that treatment would be given for only a specified period in the first instance.

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² Quitkin, F, Rifkin, A, and Klein, D F, *Archives of General Psychiatry*, 1976, **33**, 337.

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Psoriasis developing during dialysis

Remission of psoriasis in patients receiving dialysis for renal failure has been reported.¹⁻³ Peritoneal dialysis has therefore been advocated for treating refractory psoriasis in patients with normal renal function.^{4 5} We report the case of a patient whose psoriasis not only first developed during dialysis for chronic renal failure but also persisted unchanged despite three years of regular haemodialysis.

Case report

A 41-year-old white man was noted to have albuminuria in 1955 when aged 18. Intravenous pyelography showed that the right kidney was absent. He was lost to follow-up until January 1971, when he presented with end-stage renal failure. Regular haemodialysis was instituted in July 1971 via an arteriovenous shunt in the right leg. Home dialysis began in December 1971. An arteriovenous fistula in his right forearm was put into regular use in November 1975. In December 1975 he had developed typical guttate patches of psoriasis along the line of the fistula together with patches scattered widely over the trunk and scalp. He had no family history of psoriasis. The psoriasis persisted despite active treatment including at varying times dithranol, coal tar and salicylic acid ointment, and topical corticosteroids. In November 1978 he had extensive psoriasis of the scalp and hairline, widespread small plaques on the trunk (figure), and Koebner lesions along the line of the fistula in the right forearm and at venepuncture sites in the antecubital fossae. Several finger nails were pitted. The histology of a lesion on the chest showed changes characteristic of psoriasis. Haemodialysis has continued throughout apart from a two-week interlude of peritoneal dialysis

Widespread psoriatic plaques on back.

after the arteriovenous fistula clotted in May 1978. Dialysis has been adequate, biochemical and clinical criteria satisfactory, and the patient has carried on in full-time employment.

Comment

McEvoy and Kelly¹ in 1976 first reported complete clearing of psoriasis in a patient with renal failure two weeks after starting dialysis. The remission lasted for a year with dialysis and for a further 11 months after a successful renal transplant and immunosuppressive treatment. Muston and Conceicao² recorded clearing of psoriasis in one patient within eight weeks of starting dialysis and remission was long lasting. In another patient psoriatic lesions vanished within three weeks and remission was maintained for two and a half years with dialysis, but psoriasis recurred after cadaveric transplantation and cessation of dialysis. Chen *et al*³ also reported remission in two patients on haemodialysis, one of whom has remained clear for over five years. Twardowski *et al*⁴ used peritoneal dialysis for severe disabling psoriasis in the absence of renal failure. Two patients unresponsive to conventional treatment rapidly cleared with this treatment. A third patient with erythrodermic pustular psoriasis failed to respond. A further 16 patients with severe psoriasis without renal failure were treated with peritoneal dialysis over an eight-month period. All were somewhat improved, half substantially so.⁵

Owing to these reports it has been suggested that a noxious metabolite, or "psoriasis factor," accumulating over many years, in some way stimulates the increased epidermal cell turnover characteristic of psoriasis, and that it is better removed by dialysis than by normal renal clearance. Our case is the first to be reported of psoriasis developing in a patient already being treated with haemodialysis. It conflicts with the "psoriasis factor" theory. We therefore counsel caution against optimistic expectations of dramatic benefit from dialysis in patients with psoriasis.

¹ McEvoy, J, and Kelly, A M T, *Ulster Medical Journal*, 1976, **45**, 76.

² Muston, H L, and Conceicao, S, *British Medical Journal*, 1978, **1**, 480.

³ Chen, W-T, *et al*, *Artificial Organs*, 1978, **2**, 203.

⁴ Twardowski, Z J, *et al*, *Annals of Internal Medicine*, 1978, **88**, 349.

⁵ Anderson, P C, *Artificial Organs*, 1978, **2**, 202.

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