particularly around the terminal phalanges. Auscultation of the heart showed no abnormality.

Erythrocyte sedimentation rate was 45 mm in the first hour; urine contained 1 g protein/l, three red cells and five leucocytes per high-power field, and some cellular casts; and mouth culture yielded a small growth of *Candida*, and facial swabs a mixed growth of organisms. The table lists the serological titres. An electrocardiogram showed sinus tachycardia and a prolonged corrected Q-T interval of 0·4 s but was normal three weeks later. Full blood count, plasma urea and electrolytes, serum alanine and aspartate transaminases, plasma proteins, and a chest radiograph were all normal.

The fever settled spontaneously next day but the tachycardia persisted, slowing to 100/min over the five days' stay. With resolution of the fever a pleomorphic erythematous rash developed on the trunk and lasted less than 24 hours. The facial rash became more impetiginous, and she was discharged taking flucloxacillin. Two weeks later the facial rash had healed and minimal palmar desquamation was present.

Acute and convalescent serological titres in patient with MLNS

	31 July 1975	20 August 1975
Sendai	16	Not detected
Adenovirus	64	" "
Measles	2048	2048
Mumps S	128	Not detected
Mumps V	128	" "
Mycoplasma pneumoniae	256	32
Herpesvirus hominis	2048	2048
Varicella zoster	Not detected	Not detected
Leptospira	" "	" "
Cytomegalovirus	" "	" "
Influenza A and B	" "	" "
Psittacosis lymphogranuloma venereum	" "	" "
Antistreptolysin	250 U/ml	100 U/ml

Comment

This patient showed all the principal features of Kawasaki disease except indurative oedema and "strawberry tongue." Up to 70% of the patients with the disease have evidence of myocarditis,[3] and this patient was no exception. Although complete recovery is usual, 1-2% of children with the disease die suddenly, necropsy showing myocardial infarction with obliteration of the coronary arterial lumen and periarteritis nodosa.[4] Coronary aneurysms have been detected in some survivors. Renal impairment with proteinuria and leucocyturia occurs and was present in this patient.

The cause of Kawasaki disease is unknown. The aetiology was discussed by Goldsmith *et al*,[5] who reported a case in an American child. Recognition of the disease would prevent unrewarding invasive investigations such as lymph-node biopsy being carried out and enable an informed opinion on prognosis to be given.

I thank Professor D Hull for help in writing this report, and Miss Salome Anderson for secretarial work.

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(*Accepted 2 March 1977*)

Nottingham Children's Hospital, Nottingham NG3 5AF
C J HEWITT, MB, MRCP, senior registrar

Recurrence of Gilles de la Tourette syndrome

The syndrome of Gilles de la Tourette[1] is a rare triad of (1) explosive involuntary utterances including inarticulate noises and explicit obscenities (coprolalia); (2) multiple motor tics; and (3) onset in childhood or adolescence (below the age of 16). A fourth feature often noted is imitative phenomena,[2] which are also involuntary with obsessional qualities. It is commoner in males.

The present case is reported because of its unusual, episodic course and because of the close association of the renewed symptoms with psychological stress.

Case report

A 29-year-old married woman was informally admitted in October 1974. She had been adopted at the age of 6 weeks and was the only child reared by her adoptive parents. At the age of 5 she started to compulsively repeat sounds and when 8 began to blink and grimace. She had been very "clinging" to her mother and aged 9 had stayed at home for two months because of fear of leaving home. She had suffered from "asthma" between her second and fifth years. The facial tics and compulsive utterances receded when she was 11 and she remained symptom-free until the development of her current symptoms. Four months before admission she began to scream and to repeat noises, words, or parts of words which she had heard on television. Initially she screamed infrequently "just to relieve tension" but as time progressed she "barked" and made other bizzare noises daily. On the day of admission "a barking attack" lasting for an hour ended when her husband contacted their family doctor.

She described her symptoms as follows: "I'm obsessed with wanting to make as many sounds as possible; I dread going anywhere and being in company because I will start making these sounds—I will be silly and make a terrible fool of myself." She complained of being unhappy, of having lost confidence, and of having no interest in her home. The multiple tics, which consisted of blinking of both eyes, raising the left side of the mouth, and shrugging her shoulders, did not concern her. (They began shortly after her abnormal vocalisations.)

The sounds took the form of vowels of one syllable—"aou—ee—u" and were usually repeated staccato-like in bursts of one to five seconds. No complete words or obscenities were heard. She was pleasant and articulate and could not explain the form her symptoms took. The first symptoms had been the depressive ones and had been precipitated by a series of unsatisfactory events. A daughter had nearly died from pneumonia; her husband had developed a heart condition; he had incurred debts of £150 through gambling; and the family were facing eviction.

Reactive depression and Gilles de la Tourette syndrome were diagnosed. Counselling of the couple was undertaken to facilitate more effective coping and tryptizol, 25 mg thrice daily and at night, was prescribed. The vocalisations ceased within two weeks and she was discharged after one month. Her tics ceased within three months and her medication was discontinued shortly afterwards. She has been symptom-free for 18 months. The results of routine laboratory and radiological investigations were all normal, as was an electroencephalogram. Psychological assessment showed a full scale IQ (WAIS) of 105. Personality inventories (16PF, DPI, HDHQ) indicated a highly developed sense of duty; shyness; a tendency to seek few but warm relationships; above average self-directed hostility and lack of oral aggression; and some rigidity. The results of diagnostic tests (MMPI, Beck Inventory) were consistent with the presence of mild depression.

Discussion

The 18-year remission in this case is unusual. Most cases run a continuous course with an early development of tics followed several years later by abnormal vocalisations.[3]

The present episode seemed related to considerable social distress, a pattern already reported, and not uncommon in other neuropsychiatric conditions. Anxiety or depression commonly precedes the neurological changes of Huntington's chorea,[4] while depression may accompany Parkinsonism. Though haloperidol is regarded as its most effective treatment, Fernando has commented that the management of the syndrome "should be sufficiently flexible to be geared to the individual patient's needs at any particular time"—a view that could be usefully applied in the management of other neuropsychiatric conditions.

I would like to thank Dr J E Duffield and Dr A D Harris of Littlemore Hospital, Oxford, for permission to report this case and Mrs K Jambor for completing the psychological testing.

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(*Accepted 13 December 1976*)

Department of Psychiatry, University of Oxford
P A CARNEY, MRCPSYCH, DPHIL, lecturer (present address: Department of Psychiatry, University College, Galway)