of about 5 million, in the year 2002, there were more than 3.8 million individual prescriptions for antidepressants, an increase of 7% on the previous year.¹⁹ The recognition that such a serious condition with an estimated mortality of about 20%, even higher rates being reported in patients known to have organic brain disease, can occur with such commonly prescribed drugs would appear to be an important lesson.²⁰

We thank David Clark for his helpful comments on an earlier draft.

Contributors: Eileen Howitt, pharmacy manager, was involved in correspondence with the drug company and in preparation of a drug review for the patient, Tom MacEwan was the patient's RMO and adviser to the authors. AMH did the literature search and collated information on psychiatry. MW prepared the table and collated information on geriatric medicine. DH was involved in direct patient care, liaison with general medical wards, and collation of clinical data. HL was involved in the clinical care of the patient and prepared the first summary of the geriatric medicine contact after consultation with other authors before the literature search and writing of the case report. AMH is guarantor.

Funding: None.

Competing interests: None declared.

- 1 Levenson JL. Neuroleptic malignant syndrome. *Am J Psychiatry* 1985;142:1137-45.
- 2 Stevens E, Roman A, Houa M, Razavi D, Jaspas N. Severe hyperthermia during tetrabenazine therapy for tardive dyskinesia. *Intensive Care Med* 1998;24:369-71.
- 3 Anseau M, Reynolds CF, Kupfer DJ, Poncet PF, Franck G, Dresse AE, et al. Central dopaminergic and noradrenergic blockade in a patient with neuroleptic malignant syndrome. *J Clin Psychiatry* 1986;47:320-1.

- 4 Adnet P, Lesteval P, Krivosic-Horber R. Neuroleptic malignant syndrome. *Br J Anaesth* 2000;85:129-35.
- 5 Ames D, Wirshing W. Ecstasy, the serotonin syndrome and neuroleptic malignant syndrome: a possible link? *JAMA* 1993;269:869.
- 6 Sternbach H. The serotonin syndrome. *Am J Psychiatry* 1991;148:705-13.
- 7 Lane R, Baldwin D. Selective serotonin reuptake inhibitor: induced serotonin syndrome. *J Clin Psychopharmacol* 1997;17:208-91.
- 8 Kontaxakis V, Havaki-Kontaxaki B, Pappa D, Katritis D, Christodoulou G. Neuroleptic malignant syndrome after addition of paroxetine to olanzapine. *J Clin Psychopharmacol* 2003;23:671-2.
- 9 Richelson E, Nelson A. Antagonism by antidepressants of neurotransmitter receptors of normal human brain in vitro. *J Pharmacol Exp Ther* 1984;230:94-102.
- 10 Tatsumi M, Groshan K, Blakely R, Richelson E. Pharmacological profile of antidepressant and related compounds at human monoamine transporters. *Eur J Pharmacol* 1997;340:249-58.
- 11 Kawanshi C. Genetic predisposition to neuroleptic malignant syndrome. *Am J Pharmacogenomics* 2003;3:89-95.
- 12 Ballard C, Grace J, McKeith I, Holmes C. Neuroleptic sensitivity in dementia with Lewy bodies and Alzheimer's disease. *Lancet* 1998;351:1032-3.
- 13 Spivak B, Maline DI, Kozyrev VN, Neduva SA, Ravilov RS, et al. Frequency of neuroleptic malignant syndrome in a large psychiatric hospital in Moscow. *Eur Psychiatry* 2000;15:330-3.
- 14 Keck PE, Sebastianelli J, Pope HG, McElroy SL. Frequency and presentation of neuroleptic malignant syndrome in a state psychiatric hospital. *J Clin Psychiatry* 1989;50:352-5.
- 15 Gelenberg AJ, Bellinghausen B, Wojcik JD, Falk WE, Sachs GS. A prospective survey of neuroleptic malignant syndrome in a short term psychiatric hospital. *Am J Psychiatry* 1988;145:4517-8.
- 16 Hermesh H, Aizenberg D, Weizman A, Lapidot M, Mayor C, Munitz H. Risk for definite neuroleptic malignant syndrome. *Br J Psychiatry* 1992;161:254-7.
- 17 Naganuma H, Fujii I. Incidence and risk factors in neuroleptic malignant syndrome. *Acta Psychiatrica Scandinavica* 1994;90:424-6.
- 18 Deng MZ, Chen GQ, Phillips MR. Neuroleptic malignant syndrome in 12 of 9792 Chinese inpatients exposed to neuroleptics: a prospective study. *Am J Psychiatry* 1990;147:1149-55.
- 19 Information and Statistics Division Common Services Agency. Prescription cost analysis for Scotland. Scotland: ISDCSA, 2004. (Search via www.isdscotland.org.)
- 20 Shalev A, Hermesh H, Munitz H. Mortality from neuroleptic malignant syndrome. *J Clin Psychiatry* 1989;50:18-25.

(Accepted 3 June 2004)

A memorable patient

Auntie Joan

I never met Joan, but she was the favourite aunt of one of my close friends, and she died recently. My friend will miss her; he told me she was young at heart, had a wicked sense of humour, and always had a twinkle in her eye. She was loved by all her family—everyone's favourite aunt. She had lived by the seaside and had a happy life—but she grew old, as we all must, and, finally, she was admitted to one of the local district hospitals ill and anaemic.

It was clear she had some form of advanced malignancy, and an oncology opinion was needed. As is often the way, however, it was Friday afternoon and the oncologist was not on site. He therefore arranged to see her on Monday. The inevitable happened over the weekend, and Auntie Joan died with no definite diagnosis, though it was undoubtedly cancer. Despite her age, her family was left distressed, missing that crucial reassurance from an expert that everything possible had been done.

Of course, nothing could have been done. What was humbling was that my friend was sure that, had the oncologist been me, I would have gone to see her. Regrettably, I am quite sure that, after a busy week, had I been on another site, I would not have made a special trip either. My friend was also sure that a few skilful and kind words would have made his cherished aunt's sudden death more bearable. Surely not a lot to ask.

I wonder if I might have gone 10 years ago, but I am probably fooling myself. Certainly now it is not possible to provide this level of service, and maybe it never was. Today, departmental guidelines do not permit us to admit anyone to a cancer centre for assessment; a plan to treat actively is required. Under any protocol, an elderly anaemic lady with advanced malignancy is

not an oncological emergency requiring urgent assessment, especially if she is 20 miles away in another hospital. This is particularly so on a Friday afternoon, after a week of busy clinics, correcting press and internet misinformation, attending governance meetings, and travelling to multidisciplinary team meetings. Even if anyone had gone, there was clearly no effective treatment that could have been offered.

Yet, despite all our protocols and guidelines, this was still an opportunity to show compassion that was missed. Why else, after all, are we doctors? Auntie Joan was not just an elderly patient with incurable malignancy, she was a key family member, too ill by then to show much of the sparkle that endeared her so much to her family.

Will I go the next time I am contacted in similar circumstances? I don't know. Would you? If we do, Auntie Joan will certainly have been a memorable patient.

Richard Ashford *consultant clinical oncologist, Mount Vernon Cancer Centre, Northwood, Middlesex*

We welcome articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on <http://submit.bmj.com>. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.