

another concern, but validation based on medical records of clinical schizophrenia diagnoses in Stockholm County estimated that 80%-85% of these met the operational diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised.⁵

During the study period there were important changes in psychiatric care offered to patients with schizophrenia: outpatient treatment replaced long term inpatient care. In Stockholm between 1976 and 1994, the number of hospital bed days associated with schizophrenia fell by 64%, and this reduction in beds is the most probable explanation for the rising mortality. The same conclusion was drawn in a Danish study reporting increasing mortality from suicide.³ Our findings emphasise the importance of monitoring trends in mortality for patients with schizophrenia as well as for other patient groups as indicators of outcome and quality of psychiatric and medical care.

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contributed to the data analysis and discussion of the results. LB contributed to the data analysis, managed the dataset, and helped to write the paper. AE assisted in the design of the study and helped to write the paper. PS assisted in the design of the study, was responsible for designing the data analysis, performed the regression analyses, and contributed to the writing of the paper. PS and UÖ are guarantors.

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Rapid diagnosis of falciparum malaria by using the ParaSight F test in travellers returning to the United Kingdom: prospective study

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A simple diagnostic strip test for *Plasmodium falciparum* malaria (ParaSight F test, Becton Dickinson Advanced Diagnostics) detects a water soluble antigen, histidine rich protein 2, which is produced by blood stages of *P falciparum*. High sensitivity and specificity have been reported for the test in areas where malaria is endemic¹⁻³ and in studies of travellers returning from such areas.^{4,5} We compared the test with standard blood film microscopy in febrile travellers returning to the United Kingdom from such areas.

Subjects, methods, and results

We studied 160 consecutive patients aged 9-77 years presenting between April 1994 and June 1996 to our unit with a history of fever and travel in the previous year to an area where malaria is endemic. Thin films were stained with Giemsa and read by an experienced microscopist. The ParaSight F test was performed in accordance with the manufacturer's instructions; a pink band indicates a positive result. Each test took less than 10 minutes to perform. Thin films and test strips were read blind to each other.

In 45 patients falciparum malaria was the final diagnosis (table). At presentation 42 cases were detected by microscopy and 42 by the ParaSight F test. Parasitaemias ranged from <0.01% to 15% of erythrocytes parasitised. In one patient, the test was positive at presentation, and scanty (<0.001%) *P falciparum* trophozoites were detected on blood film only on day 2. In two other patients both the blood film and the test gave negative results at presen-

Results of tests for infection with *Plasmodium falciparum* and subsequent diagnosis. Values are numbers of patients

Blood film	Presentation	Final diagnosis	
		<i>P falciparum</i> (n=45)	Other malarial species (n=115)
Positive	Positive	41	0
Positive	Negative	1	0
Negative	Positive	1	2
Negative	Negative	2	113

tation but positive results on subsequent days. One patient had a positive test with a negative blood film; three days previously he had had halofantrine treatment for presumed malaria. One patient with pneumococcal meningitis had positive tests over three days with negative daily blood films. The test was negative in one patient with a *P falciparum* parasitaemia of <0.01%.

Test results were negative in all 113 other patients who did not have *P falciparum* infection, including 27 infected with other malarial species (23 with *P vivax*, 3 with *P ovale*, 1 with *P malariae*). Other diagnoses included diarrhoeal disease, dengue fever, typhoid, pneumonia, urinary tract infection, brucellosis, acute myeloid leukaemia, and infectious mononucleosis.

Compared with the final diagnosis, the ParaSight F test used at first presentation had a sensitivity of 93.3%, a specificity of 98.3%, a positive predictive value of 95.6%, and a negative predictive value of 97.4%.

Comment

The *ParaSight F* test is simple, rapid, and has adequate sensitivity and specificity for initial assessment of *P falciparum* infection in returning travellers. It identified all patients with *P falciparum* apart from one patient with a low parasitaemia of <0.01% and two patients with parasites not detected on initial microscopy. Positive test results in the patient treated with halofantrine are explained by the established persistence of histidine rich protein 2 in the blood for up to 10 days. Positive results of the patient with pneumococcal meningitis were taken to be a genuine false positives.

The test does not remove the need for blood film examination as it is not 100% sensitive at low parasitaemias, and repeated daily testing may be necessary to establish the diagnosis. Nor does the test give any indication of density of parasites, essential in planning management.

The *ParaSight F* test has a useful role in the initial screening of febrile returning travellers with suspected falciparum malaria, particularly where laboratory staff are not experienced in diagnosing malaria. The test can be considered a "side room" investigation, as it requires no special training. It may also be used to dis-

tinguish between the benign malarias and the potentially lethal falciparum malaria.

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Homage to delirium

I recently started a fellowship in geriatric medicine at a large academic facility, and it was with some trepidation that I saw the list of my patients for the next two years—"dean of this," "professor of that." Fresh from residency in a community based hospital, I felt as if these figures from medical school clinical examinations had come back to haunt me.

And then "professor of that" was admitted to hospital. I spent some time with this retired medical school dean, when he entertained us with his past glories. I did not expect him to succumb to a delirium so shortly after admission. Perhaps part of me failed to accept that a great academic figure could so rapidly become just like the other frail, grey souls struggling with reality in their hospital beds.

As we rode the wave of his fluctuating mental state his failing heart incited a pharmaceutical tug of war as evidence based medicine conflicted with a need for simplistic prescribing. I wanted to hurry him back to his familiar environment. Despite it all, some of the old magic was hinted at. I chuckled as he bullied the new interns into obtaining unnecessary investigations for the slightest symptom.

And then he sank deeper into confusion. The attending physician's eyes registered great concern, and I knew then that I wasn't alone in feeling some sadness in seeing a great member of our profession slip.

"But I must get to Hopkins," he cried, his delirium in full force, "I must deliver this paper. My son's making the arrangements, you have met him I believe," introducing me to a white wall. To those walking past his room he was like any other frail old man teetering at his walking frame like a branch swaying in a cruel breeze. Inside, however, I was witness to a strange and compelling discourse. The turbulent sea of his thoughts had whisked him to a lecture hall distant in place and time. His walker was transformed into a podium by his delusions; he sprang to life, restored to his former professorial glory as lecturer as he addressed the halluciniform crowd.

My initial instinct was to redirect him back to reality. On the other hand, to bask again in the academic limelight seemed to be therapeutic for him. While ensuring that he didn't topple over, I did little to end his grand delusion. I was privy to an experience akin to hearing Dr Parkinson lecture me on "the shaking palsy."

If I have learnt anything from my experiences with the professor, it is that delirium is more than just a confused patient. It is a state unique to the individual that draws on the entirety of his or her life experiences. As such, I have a clearer understanding that though delirium can be easily diagnosed, it is rare that we are given the chance to contextualise the abnormal thought processing. Perhaps if we knew our patients' passions in more detail we could understand what lies behind the manifestations of their confusion. A great man can still be a great man in the presence of an acute confusional state, and it is this knowledge that gives me joy in caring for patients in their twilight days.

And now as I pass the chief resident's office on my way to rounds, I dwell for an instant by my patient's photograph labelled "Housestaff 1935-6" and wonder if I will be lucky enough to have my delirious ramblings impact on someone so deeply.

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We welcome articles of 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. If possible the article should be supplied on a disk. 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.