LETTER TO THE EDITOR

Sir,

In a recent article on 'khat,' Kalix (1988) discusses the toxic reactions to this substance, its similarities to amphetamine, and the implications of treatment for such patients. We have recently reviewed nine case reports of psychosis related to the use of khat as well as three of our own cases (Pantelis et al., in press). We have also compared these reactions to those observed in amphetamine abusers, and a number of similarities are apparent, as discussed by Kalix. Kalix rightly points out that these toxic reactions are exceptional. However, a relatively large number of cases have been reported in Western countries compared with countries where khat consumption is common, and there may be a number of reasons for this. For example, it has been pointed out by Luqman & Danowski (1976) that in khat-using areas where health facilities are lacking, persons with psychosis are usually locked in their homes by their families until the episode subsides. The cases in the UK were characterized by the solitary use of khat in young individuals who had few social supports. The solitary use of khat is unusual and it may be that these individuals are a more vulnerable group and thus more susceptible to the adverse effects of khat. This vulnerability may be a necessary prerequisite to developing a khat psychosis, as its most active ingredient, the alkaloid known as cathinone, is less potent than amphetamine, relatively unstable, and rapidly metabolized. Also the mode of consumption of khat leaves makes it difficult to achieve high blood levels (Halbach, 1972). The issue of vulnerability is discussed in relation to amphetamine psychosis by Gold and Bowers (1978). Jaffe (1980) discusses the association between social dislocation and abnormal patterns of drug use, and Giannini and Castellani (1982) reinforce this view for khat abuse. The concomitant use of alcohol which has been reported (Omolo & Dhadphale, 1987) may also play an important contributory role, though this was a feature in only one of the cases we discussed.

In the three cases that we reported and the further nine cases we reviewed in the literature, three reactions were apparent, though two types of reaction seem most prominent. First, there is a paranoid psychosis with prominent delusions of persecution often associated with auditory hallucinations in a setting of clear consciousness. This pattern most closely resembles the paranoid psychosis seen with amphetamines. Other first-rank symptoms, for example, thought broadcasting and passivity experiences, were also present in this subgroup of patients with khat-induced psychosis. A second reaction seen in five cases was of a manic illness with grandiose delusions, usually without auditory hallucinations. A third and less commonly reported response is of a depressive illness, which occurred in two of our cases. This seemed to result from a relative decrease in khat intake preceding a further heavy khat session, at which time paranoid delusions became prominent. No mention is made of depressed mood in any of the other cases, in particular, that reported by Critchlow & Seifert (1987) in which there was attempted suicide. The importance of this latter reaction to khat is perhaps underestimated by Kalix who mentions mild depression as a withdrawal phenomenon. In one of our own cases, khat-induced depression was severe though short-lived and resulted in suicide-homicide.

In all 12 cases we reviewed, the psychosis developed after a recent heavy or increased use of khat. In all but one case, the episode rapidly resolved within one to two weeks of stopping khat. There was a tendency for the psychosis to recur with the recommencement of khat. Antipsychotics were used in nearly all of the cases, and Kalix reviews the possibilities for the use of antipsychotic medication in the treatment of khat psychosis. The most consistently beneficial treatment strategy, however, is the withdrawal of khat rather than the use of antipsychotics. Thus, though it would seem appropriate that antipsychotics are used in the treatment of severe khat psychosis, it may not always be essential, as was apparent in one of our own cases, and more attention to social and psychological aspects of management may be warranted in the prevention of further such reactions.

Finally, Kalix concludes that preventive prohibition should be considered in developed countries before there is an increase in the khat habit. As far as the UK is concerned, we think that there is clearly a need to monitor the growing use of khat in view of the seriousness of two of the cases we reported that involved attempted homicide and suicide-homicide.
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REFERENCES


