occurred suddenly and was treated promptly. The patient succumbed to repeated asystole on the sixth day.

Serum taken on admission contained: lithium, 0.38 mmol/l (therapeutic range 0.5–1.0); diazepam, 0.33 mg/l; and nordiazepam, 0.5 mg/l. No tricyclic antidepressant was detected. Unfortunately, assay for monoamine oxidase could not be performed.

Autopsy showed massive centrilobular hepatocellular necrosis and some fibrin thrombi within glomeruli. Muscle histology and histochemistry were normal.

This appears to be the first case of NMS associated with therapeutic doses of lithium and MAOI. Perhaps the particular sequence of drugs employed, with phenelzine replacing clomipramine, was an important factor in this instance. The current nomenclature might easily have hampered early diagnosis and appropriate treatment, although in this case intravenous dantrolene was not successful.

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Reference

LEVENSON, J. (1985) Neuroleptic malignant syndrome. *American Journal of Psychiatry*, **142**, 1137–1145.

Clastogenic Factors and Abnormal Plasma Fractions in a Female Patient with Severe Aggressiveness

SIR: A patient with a very long history of severe and therapy-resistant aggressive-destructive features has been examined.

Case report: The patient is a 32-year-old woman. Psychiatric problems have been present since early age, and the parents consulted a child psychiatrist when the patient was 4 years old. She has been in hospital from the age of 10, for 22 years. Several modes of different long-term intensive psychotherapy as well as numerous types of psychopharmacological agents have been tried. During the past five years she has been committed to an isolated ward as a single patient with a total of 15 mental health assistants. She is presently being treated mainly with long-term psychotherapy. Over the years there have been no signs of improvement.

The symptoms leading to this tragic situation are aggressiveness, destructiveness, feeding problems of anorexic-bulimic type, smearing with faecal matter, strange rituals, overactivity, paranoid features, and communication problems. She has a normal intelligence level and has been able to learn to speak, read, and write, and communicates intensively by letter.

An extensive investigation of the patient was started, and during chromosomal examination according to Gustavson *et al* (1983), a hyperdiploidy of her lymphocytes cultured in plasma was noted. This finding, indicating mitotic instability, led to the search for clastogenic factors in the plasma of the patient. Elaborate biochemical studies revealed two abnormal plasma fractions: one polypeptide with a molecular weight of $3–12 \times 10^3$ and one protein with a molecular weight of more than 10^5. When blood plasma was dialysed against an excess of phosphate-buffered saline (pH 7.4), most of the clastogenic activity was retained in fractions larger than 12×10^3. Similar abnormal plasma fractions were also found in her mother and one of her younger brothers.

Several other examinations have been performed, and detailed results will be presented elsewhere. Hypothetically, the clastogenic factors and the abnormal protein fractions in the plasma may be related to the psychopathology of the patient. We ask readers to contact us if they have observed a similar case or may provide us with a clue to this severe psychiatric disturbance.

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Reference

GUSTAVSON, K.-H., JANSSON, R. & ÖBERG, K. (1983) Chromosomal breakage in multiple endocrine adenomatosis (types I and II). *Clinical Genetics*, **23**, 143–149.

Atypical Koro

SIR: Koro is a relatively rare symptom complex that has been reported to occur throughout the world. The typical episode was described among the Chinese by Yap (1965) as an "unfamiliar state of acute anxiety with partial depersonalisation leading to the conviction of penile shrinkage and to fears of dissolution". Koro has also been reported in a variety of non-Chinese subjects (Edwards, 1984). Atypical cases of koro are generally of a chronic nature and are secondary to a variety of other psychiatric conditions (Yap, 1965). Generally, cases described among South-east Asians are related to an

anxiety disorder, while those in the West are more often related to psychoses or intoxication (Ede, 1976; Edwards, 1970). The case reported here involved koro-like symptoms of an atypical nature.

Case report: A 36-year-old, single, Jamaican male was admitted to a general psychiatric in-patient unit with a chief complaint of "my testicles are swollen and bother me." Since onset of the problem one year earlier, he had become progressively more preoccupied with his testes, often scrutinising and holding onto them out of fear that they would be withdrawn into his abdomen. He feared that he would die if retraction was complete. The patient had first been admitted to hospital and diagnosed as schizophrenic, paranoid type, nine years earlier.

During the course of his hospital stay, he was treated with oral fluphenazine hydrochloride, which helped to ameliorate his fear of genital retraction. Exacerbation of his anxiety in anticipation of a weekend pass was successfully treated with lorazepam (1 mg qds). Addition of desipramine (150 mg) for six weeks provided no demonstrable benefit. Following a five-week hospital stay, the sensation of genital retraction and associated fear were modestly reduced; however, the patient felt better able to tolerate the situation and he was discharged to out-patient treatment.

Recent reviews have suggested that koro is not a unitary phenomenon and that while one variety appears to be a culture-bound anxiety disorder, another form appears as a delusional system (Ede, 1976; Edwards, 1970). The present case provides support for such a dichotomous approach (Sachdev, 1985) to the classification of koro.

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References

EDE, A. (1976) Koro in an Anglo-Saxon Canadian. *Canadian Psychiatric Association Journal*, **21**, 389–392.

EDWARDS, J. G. (1970) The Koro pattern of depersonalization in an American schizophrenic patient. *American Journal of Psychiatry*, **126**, 1171–1173.

EDWARDS, J. W. (1984) Indigenous koro, a genital retraction syndrome of insular Southeast Asia: a critical review. *Cultural Medical Psychiatry*, **8**, 1–24.

SACHDEV, P. S. (1985) Koro epidemic in India. *Australian and New Zealand Journal of Psychiatry*, **19**, 433–438.

YAP, P. M. (1965) Koro – a culture-bound depersonalisation syndrome. *British Journal of Psychiatry*, **111**, 43–50.

Successful Treatment of a Chinese with Primary Ejaculatory Failure

SIR: The Chinese are well-known for their inhibited attitude towards sexual problems (Ho, 1986). Crown & d'Ardenne (1982) have also commented on the difficulty of treating non-Caucasians with conjoint sex therapies. Successful treatment of a Chinese with primary ejaculatory failure is reported. This is the only case presenting with psychosexual disorder in my three years' practice in our psychiatric unit, with a catchment population of 641 000!

Case report: Mr C. is a 33-year-old store-keeper, who emigrated from China to Hong Kong with his wife 6 years ago. He was referred by the endocrinological unit for primary ejaculatory failure after all physical examinations and investigations were negative. The patient was brought up in a traditional Chinese family in which discussions of sex were prohibited. He had masturbated while fantasising about female nude figures about twice per week since age 16. He could achieve erection easily during masturbation but could never ejaculate, yet he had nocturnal emissions about twice per month. He never had sexual relationships except with his wife. Since their marriage, 7 years previously, they had often quarrelled, because the patient played mahjong and neglected his wife at weekends. They had sexual intercourse about twice per week. Every time the patient could achieve erection easily, but failed to ejaculate. Both wanted to have a child.

When the patient was first referred to me, he vigorously denied that his ejaculatory failure was psychogenic and refused to bring his wife for conjoint therapy, even though I pointed out to him that presence of nocturnal emissions virtually excluded organic pathology. I suggested that he visit a prostitute to see whether he could ejaculate. In the following week, he happily reported that he had ejaculated for the first time in his life with a prostitute. The patient now agreed to bring his wife for conjoint therapy. I first helped the couple to resolve their marital conflict – the patient finally agreed not to play mahjong on Sundays. Then the couple were given written instructions of the method of 'super stimulation', with extravaginal and later intravaginal ejaculations as detailed by Bancroft (1983). After four weeks of graded assignments, the patient could ejaculate intravaginally with his wife.

This case demonstrates that the Chinese can be treated with conjoint sex therapies when they have been convinced of the psychogenic nature of their problems. In this case, this was done by 'permitting' the patient to ejaculate with a prostitute. After the successful ejaculation had removed his inhibition, he responded rapidly to conjoint sex therapy.

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References

BANCROFT, J. (1983) *Human Sexuality and Its Problems*, pp. 255–256. Edinburgh: Churchill Livingstone.