1980), but as yet there is no satisfactory or widely accepted definition of HVS. Until this deficiency is remedied it will not be possible to determine the relation between hyperventilation, i.e. objective evidence of hypocapnia, and symptoms reported during episodes of panic. Secondly, we need to be much more rigorous in excluding organic disorders that can present with anxiety or panic symptoms (Jacob & Rapport, 1984). We have recently demonstrated that organic lung disorders may provide the initial stimulus for breathlessness in patients with symptomatic hyperventilation (Gardner & Bass, 1984). Elaborate investigations may be required to exclude these disorders. We are not told how organic disease was excluded in Kraft and Hoogduin's patients.

Diagnosis may be difficult in patients with acute, intermittent hyperventilation who may be normocapnic between episodes. We have suggested elsewhere (Bass & Gardner, 1983) that ambulatory CO_2 monitoring may provide useful information in such cases, but this technique is not yet widely available. We have devised a protocol in which $PACO_2$ is monitored uninvasively in the laboratory over long periods, including sleep. End-tidal pCO_2 is carefully measured whilst the patient is subjected to a number of standardised stressors, including exercise and forced overbreathing. The technique is reliable and acceptable to patients, and provocation of hypocapnia during the procedure is highly suggestive of HVS.

In view of the heterogeneity of HVS (acute and chronic forms occur in clinical practice), we believe it is essential to establish objective diagnostic criteria before subjecting patients with vague and non-specific symptoms to trials of treatment. Otherwise hyperventilation syndrome (or more correctly "symptomatic hyperventilation") is destined to acquire the status of Briquet's syndrome: a clinical entity of dubious validity characterised by a conspicuous lack of positive diagnostic features.

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KORO IN NON-CHINESE SUBJECTS

DEAR SIR,

I was interested to read the reports concerning koro symptoms in non-Chinese subjects. I have recently encountered a further case, which I report here:

A 25 year-old previously well single black male presented with acute anxiety and the conviction that his penis was retracting into his abdomen. Onset was sudden, after erectile failure during attempted coitus. Fear of impotence had existed for 8 months, since he had been an unwilling participant in a tribal ritual during which he was circumcised. He was of good intelligence, with no hallucinations or other delusions. His condition deteriorated while being treated with clomipramine 75 mg per day, and he eventually became mute and catatonic. Haloperidol 30 mg per day resulted in rapid improvement, but he remained convinced that his penis was shrinking.

The exact nosological status of this patient's condition is unclear, perhaps best fitting Ang and Weller's description (*Journal*, September 1984, **145**, 335) of an acute anxiety state and delusional belief due to an underlying psychotic illness. However, the clear-cut initial sensitising experience and the ultimate precipitating event are in keeping with the psychogenic syndrome described by Yap (*Journal* 1965, **111**, 43–50).

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DEAR SIR,

I have read with interest the reports of koro-like symptoms in non-Chinese subjects in several psychatric conditions. I here report a relevant case:

A 60 year old Scotsman married with 3 children was referred for withdrawal from lorazepam. He had been treated with 4 mg daily 10 years before, after developing cardiac dysrhythmia. Withdrawal after some months precipitated feelings of restlessness, and ringing in his ears and he was replaced on lorazepam 10 mg daily until 3 years ago when he was admitted to hospital to be withdrawn from it. On the 10th day after discontinuation he was agitated, restless, and tearful; he felt numb around his mouth and thought his whole body was shrinking and his penis and testicles were disappearing almost as though he was changing into a woman. He did not believe the

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