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progressively more preoccupied with his testes, often scrutinising and holding onto them out of fear that they would be withdrawn into his abdomen.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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## 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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## Bipolar Affective Disorder and Thalassaemia Minor – A Genetic Linkage?

SIR: We report a woman with thalassaemia minor and bipolar affective disorder.

*Case report:* An Italian woman presented for the first time at the age of 35 years in 1976 with an unipolar depressive episode requiring ECT. Since then she has been admitted on seven occasions, mostly suffering from manic episodes. Her last admission was in July1984. She also had a concomitant history of thalassaemia minor and was noted to be anaemic on several of her admissions, requiring blood transfusions. Only one other relative, a brother, had bipolar affective disorder, but in his case no evidence of thalassaemia minor was found. Our patient responded well to conventional treatment while in hospital, but was extremely non-compliant regarding follow-up and medication. On her last admission she was noted to have splenomegaly (3 fingers), with haemoglobin of 9.5 g/100 ml. Her blood film showed evidence of hypochromasia, microcytes, basophilic stipling, and tear drop cells. She required transfusion on this occasion.

An extensive literature search revealed only one previous case report of this kind (Joffe *et al*, 1986). In our case we were able to confirm haematologically the diagnosis of thalassaemia minor, and an interview with the patient's brother confirmed his diagnosis of bipolar affective disorder. Genetic linkage studies of bipolar affective disorder to date have yielded conflicting results. However, some studies have supported an X-chromosome transmission hypothesis using X-linked colour blindness (Mendlewicz *et al*, 1979) and glucose-6-phosphate dehydrogenase deficiency as genetic markers (Berrettini *et al*, 1984). Joffe *et al* (1986) state that their case study provided evidence suggestive of a relationship and a possible linkage between bipolar affective disorder and thalassaemia minor. They speculated that since the short arm of chromosome II contains the adult β-globin gene and partial deletion of this gene leads to the heterozygous form of β-thalassaemia, that a possible site for the gene locus conferring susceptibility to affective disorder may occur on this chromosome. We are loath to further speculate on this, the second reported case. Perhaps a systematic review of susceptible populations, e.g. countries bordering the Mediterranean, might be worth considering.

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## "Affective Disorders in the Elderly"

SIR: May I briefly comment on the review of this book (*Journal*, November 1987, **151**, 716). Dr Garry Blessed, a well-known figure in geriatric psychiatry, provides what might be called a bluff review. His particular comment on our chapter on the relationship between physical illness and depression, wherein we looked at interactions, is that it clouds rather than clarifies.

Unfortunately for Dr Blessed, clinical horse sense is no longer good enough and multivariate analysis is with us, whether we like it or not. It may seem inchoate at times, but it has rendered simplistic clinical statements obsolete.

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