things are alike and different, depending on the purpose for the comparison. If the similarity can be said to be slight, moderate or marked, a dimension and measure can be used. As mathematics serves but does not produce purposes, statistical techniques cannot classify objectively, nor discover dimensions.

Kendell and Brockington talk about valid boundaries; we would prefer useful boundaries within a language and an attitude, because then one is led to ask about the origin of the language and attitude and the usefulness for whom? They talk about small changes in symptoms causing big changes in outcome, but here small and big are also difficult words, depending on the units.

There is nothing to be gained except coherence within a linguistic convention by any answer they can obtain. In their language it is difficult to produce evidence for schizophrenia and manic-depressive illness as distinct entities, but they fail to see they are defining when an entity or dimension shall be declared to exist in psychiatry.

Perhaps the oft-discussed distinction between bushes and trees in English might illustrate some of our points. What, for example, would a linear variable from discriminant function analysis on the abscissa mean, and what difference would there be between a categorical and a dimensional approach? The distinction was presumably made for reasons related to our lives, especially perhaps in farming, but it doesn't help much in collecting firewood. The response of schizophrenics to phenothiazines, and of manic-depressives to lithium, seem to be among reasons for maintaining the words, but the traditional use of the words may have affected the psychopharmacological view we now take. The danger of a portmanteau approach could be being restrictive. Such an approach is fostered by a belief in the possibility of objective nosologies based on mathematics. That could even induce a new alchemy of searching for the 'philosopher's stone', it could make us too content that our language of discourse is almost correct and suppress alternative more idiographic approaches to the mental miseries of our patients (other men). They may after all not be ill in any simple sense. The ideological rejection by some of them of our common sense, for example, may in the ensuing mêlée be producing much which we are 'mathematically objectifying' as psychopathology. Our struggle for a pseudo-objectivity, inevitable labelling and distancing etc., are all part of that mêlée, and they force our common sense back onto life's comparative chaos, as others ought to be like us. But it might be difficult for them, hence Babel may be intellectually more honest, fertile and true than a universalized language partly arising from mathematics, of which the foundations themselves are currently receiving scrutiny from thoroughgoing pragmatists. For every n clearly defined items there are 2^n-1 clearly definable things; which do we want, when and for what?

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LUNG CANCER AND SCHIZOPHRENIA

DEAR SIR,

May I refer again to the idea of other correspondents (e.g. Jancar (1978)) that heavy-smoking, long-term schizophrenics suffer much less lung cancer than is statistically expected? If it is true it is a very considerable fact and calls for verification or dismissal.

I was surprised that no mention was made of Kissen's (1967) investigation of psychosocial factors, personality and lung cancer in men aged 55–64 (average 59), studying random thoracic department patients before diagnosis. Of 366, it transpired that 218 had lung cancer and 148 did not. Marital or domestic status, position in the family, religion, and county of birth of patients or parents, had no cancer significance. The slight excess in classes 4 and 5 was not important, but unhappy childhood homes, early orphanage and stress in life situations, especially long-standing interpersonal ones and those developing over time at work, did seem significant. Kissen found silence and denial among lung cancer patients who "tend to repress significant emotional events", with an unconscious containment of conflict. Patients themselves often sensed a poor outlet for emotional discharge.

Of thousands of hospitalized long-term, heavy-smoking schizophrenics seen by me over the last three decades, their greatest blessing has been freedom to spend their substantial cash allowances on cigarettes, at the hospital shop or outside the hospital. For patients who had run out of cigarettes and money, the commonest effective calming medicine, producing immediate satisfaction, was absorbed from cigarettes.

The Records Officer at St Crispin Hospital, Northampton, provided the figures that over the last 23 years, of 2,363 patient deaths 22 were due to lung cancer. I examined the notes of the 22 and only one, an ageing woman who had lived effectively and unsupported in the community for most of her life, was schizophrenic.

Assuming for the sake of argument that Kissen and I are reporting facts, then it is a reasonable hypothesis that long-term schizophrenics, outwardly calm like Kissen's patients, have no capacity for the

repression of significant emotional events and no need to contain emotional conflict. Jancar's (1978) contribution to the discussion suggests that this is shared by the severely mentally handicapped, not many of whom would have been taking phenothiazines, a possible causal agent put forward by Schiff (1979).

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ANOTHER CASE OF KORO IN A BRITON

DEAR SIR,

Over the last fifteen years, at least three cases of koro-like symptomatology have been described in Westerners (Barrett, 1978; Edwards, 1970; Yap, 1965). I would like to report another recent case of koro-like symptoms occurring in an Englishman.

The patient is a young man of 24, who has never been out of Europe. He has one aunt who was repeatedly admitted to hospital suffering from a depressive illness, and both his parents are described as being of nervous disposition. Apart from enuresis up until the age of eight, the first hint of abnormality in his personal history was at the age of twelve, when he began cross-dressing in his sister's clothes and masturbating. There were no homosexual fantasies. He continued to do this once or twice a week until the age of eighteen. Meanwhile there was a very insidious onset, from about the age of fourteen, of irrational fears, obsessive-compulsive symptoms, hypochondriacal complaints, labile mood, outbursts of violence, heavy drinking, and recurrence of nocturnal enuresis. There was no history of drug abuse.

At the age of eighteen he attempted sexual intercourse on three separate occasions, and was impotent. He became extremely upset about this, began drinking heavily, and developed numerous fears about his health, including a worry that there might be something wrong with his penis. In 1977, at the age of 21, he was admitted to a psychiatric hospital suffering from severe anxiety associated with obsessional thoughts and rituals.

After discharge he was walking down a street one afternoon when he suddenly felt his penis shrinking to 'about half an inch in length'. He became very frightened, returned home, examined himself, and claimed that he could see and feel that his penis was disappearing into him. He feared that it might disappear altogether, and that he would then die or have to kill himself. Since then he claims to have this 'shrinking' sensation all the time, with more acute episodes occurring almost every day, during which he feels his penis becoming even smaller. At these times he becomes extremely agitated, panicky, and distressed. He believes that he may have a very rare physical illness, although he has never heard of koro himself, or met anyone with similar symptoms.

Later, he became very depressed and withdrawn, as he felt that the shrinkage of his penis must be immediately apparent to everyone. In early 1969 he began hearing a single male voice which called him unpleasant names, ordered him to carry out various rituals, and threatened him with his mother's death. He also developed ideas of being controlled by outside agencies.

In July 1979 he was admitted to hospital. Physical examination showed nothing abnormal. He was withdrawn from alcohol, and treated with psychotherapeutic interviews and a variety of drugs including amitriptyline, combined amitriptyline and phenelzine, pimozide, chlorpromazine and haloperidol. However there was little improvement in his overall state, and two years later, his acute episodes of koro-like symptoms are as frequent and distressing as ever.

This patient is similar to the cases described by Yap (1965a and 1965b), including the case he described in a Briton, in many ways: the young adult age, being an only son with over-dependence on his mother, the story of unusual sexual conflict and maladjustment, and the associated symptoms of hypochondriasis, depression and heightened self-observation of the genitals before the onset of the classical feeling of the penis shrinking.

Diagnostically he remains a puzzle, exhibiting obsessional traits, depression, auditory hallucinations, and vague feelings of being controlled. Obsessional traits and schizophrenia-like symptoms occurred in Edwards' (1970) case in America, and Yap reported six cases against a schizophrenic background. The features of the koro syndrome appear to be less culture-bound than was originally thought.

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