

Two Cases of Koro-like States Occurring in Sri Lanka

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Summary

The culture bound syndrome of penile shrinkage 'Koro' was originally described as occurring exclusively in people of Chinese origin. Recently a number of cases of Koro has been reported from other cultures. This report is of two such cases of Koro-like states occurring in Sri-Lanka, in people of non Chinese origin.

Introduction

Koro is a clinical syndrome characterized by the conviction that the penis is being withdrawn into the abdomen and will eventually cause death. This is associated with intense panic and preventive manoeuvres may be instituted.¹ It was originally thought to be a culture bound syndrome occurring in the Chinese or Malaysian subjects of Chinese origin. The term Koro in Chinese stands for, the head of a turtle.

Case 1

A well built Sinhalese man, 21 years of age, was seen at home, running about naked holding his penis and shouting that the organ was shrinking into his abdomen and that as a result he would die. He was restrained with difficulty and removed to hospital. The panic subsided after two days on chlorpromazine injections.

The history was that he had just left school and this was his first psy-

chiatric breakdown. A family history of schizophrenia was obtained on the maternal and paternal sides. The patient was aggressive and over talkative. He became quite anxious when speaking about his Koro-like symptoms. He had thought interference and broadcasting. There were strong paranoid ideas — he was being spied on and charms were being introduced into his food. He had ideas that a member of the clergy was controlling him. There were menacing auditory hallucinations. As there was a history of childhood convulsions an EEG was done which was within normal limits. Insight was poor. A diagnosis of schizophrenia was made, and large doses of chlorpromazine were given orally and intramuscularly. He continued to remain overactive and even attacked members of the staff and other patients. 4 ECT were then given, and he responded well. He became quiet and his psychotic symptoms regressed. The Koro-like symptoms were the first to regress. He was discharged from hospital in 3 weeks but unfortunately came under the influence of the clergyman who induced him to stop the neuroleptics, saying that the illness was one of demoniac possession. Two months later the patient committed suicide by jumping off a high rise building.

Case 2

This young man a muslim age 22 years working at a hotel resort in

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Southern Sri-Lanka was seen in a state of extreme agitation. He thought that his penis was being slowly drawn up into his abdomen. The symptom was of 3 weeks duration and had begun after the patient developed a venereal disease from a homosexual contact. He was successfully treated for this ailment, but a doubt lingered that his penis had become smaller and would eventually disappear into his abdomen. He developed obsessional compulsive symptoms, where he had to hold and observe his penis every half hour to check that no withdrawal was occurring. In addition to the anxiety there was a mood depression with early morning awakening. He did not envisage a fatal outcome. He did well with reassurance and clomipramine 50 mg b. d. With the improvement in mood his Koro-like symptoms regressed.

Discussion

The classical Koro syndrome of the belief of penile shrinkage, withdrawal into the abdomen and fatal outcome associated with severe anxiety had been seen earlier only in the Chinese. This is a culture bound syndrome, as amongst the Chinese, ideas of penile shrinkage and loss are common, and some cultures had even produced penile clamps as a preventive measure.² 15 cases have been reported in non-Chinese subjects all of which appeared as over-valued ideas or delusions occurring secondarily to other psychiatric illness.³ Oyeboade et al demonstrated true shrinkage in penile circumference during the panic situation using penile plethysmography in one non-Chinese subject.⁴ They concluded that the patient had dysfunctional autonomic control of his penile size, leading to dim-

inution. [They thus queried the over-valued ideas and delusional [content of the syndrome. Recently Devan and Hong has attempted] a possible classification of the syndrome into (1) Classical Koro. This occurs in the Chinese, is of cultural origin and is not related] to any underlying psychiatric illness. (2) Koro grafted on an underlying psychiatric illness usually associated with anxiety states. Here too a cultural basis is possible. (3) Koro as a symptom of mental illness.⁵ There is no cultural basis and the symptom is based on a delusion or is a result of depersonalisation accompanying schizophrenia or other psychoses. The symptom resolves with the resolution of the psychosis. The association with schizophrenia is rare but has been reported by Yap⁶ and Cremona.⁷

To the best of our knowledge the two cases described in this paper are the first two cases to be reported from this country. They have both occurred in non-Chinese subjects and the symptoms resolved with the treatment of the underlying illness. In the first patient, the Koro was the presenting primary delusion in a schizophrenic man who had all three signs of classical Koro and would fit into the third category of Devan and Hong's classification. The second patient was a Muslim. The Muslims have culture bound ideas regarding the penis, because circumcision is mandatory in this culture and have caused fears in adolescents. The operation too is an occasion for celebration in the Muslim community, and overvalued ideas of the penis exist. In this patient anxiety was a prominent symptom and would include him in the second category.

REFERENCES

1. Yap P M. Mental Disorders peculiar to certain cultures. A survey of comparative psychiatry. *The Journal of Mental Science*, 1951; 97: 313-327.
2. Rubln R. T. Koro. A culture bound Psychogenic syndrome. *Extraordinary Disorders of Human Behaviour*. (C. Friedman and R. Faguet). N. Y. Plenum.
3. Berrios G E, and Morley S J. Koro-like symptoms in a non chinese subject. *British Journal of Psychiatry*, 1984; 145, 331-334.
4. Oyebode F, Jamieson R, Mullaney J, and Davison K. Koro — A psychophysiological dysfunction. *British Journal of Psychiatry*, 1986; 148, 212-214.
5. Devan G S, and Hong O S. Koro and Schizophrenia in Singapore. *British Journal of Psychiatry*, 1987; 150, 106-107.
6. Yap P M. Koro a culture-bound depersonalisation syndrome. *British Journal of Psychiatry*, 1965; 111, 43-50.
7. Cremona A. Another case of Koro in Britain. *British Journal of Psychiatry*, 1981; 138, 180-181.