

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

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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 $3\text{--}12 \times 10^3$ 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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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