A case of two culture-bound syndromes (Koro and Dhat syndrome) coexisting with obsessive–compulsive disorder

Sir,

Koro is a culture-bound syndrome and is quite prevalent in both epidemic and sporadic forms in South East Asia. Several reports on Koro in the literature have proved that India, after China, is a Koro prone country. India had a massive Koro epidemic in 2010, involving states of West Bengal, Maharashtra, Assam, Tripura, and Kerala.[1-5] Here, we report a case of Koro from the 2010 epidemic background in West Bengal, who is having two culture-bound syndromes – Dhat and Koro with comorbid obsessive–compulsive disorder (OCD).

An 18-year-old single Muslim unemployed male (who has consented for this study) from a rural community visited the hospital with complaints of perceived excessive semen loss through urine, lethargy, disturbed sleep, and weakness for the past 4 months and an inward pulling sensation of the penis toward the abdomen with severe anxiety and fear of serious illness for the past 3 days. There was an ongoing “Koro” epidemic in his locality for the past 2 weeks, and several others were reported to be having similar symptoms. Mental status examination revealed severe anxiety (hamilton anxiety rating scale (HAM-A)-29) along with strong masturbatory guilt. He was diagnosed as a case of Koro with Dhat syndrome (international classification of diseases-10th revision (ICD 10)-F41.1) and treated with sertraline 50 mg/day gradually increased to 100 mg in a week, clonazepam (1 mg/day in two divided doses), and supportive psychotherapy. The patient reported on an unscheduled visit 5 days later with a new complaint of having recurrent intrusive distressing blasphemous thoughts, the content being vulgar sexual abusive thoughts directed toward Allah (God). He experienced severe guilt and anger and started repeatedly abusing and beating his head to stop the thoughts though the relief was temporary. He was now additionally diagnosed as a case of OCD (ICD-42.0), with yale brown obsessive compulsive scale (Y-BOCS) score 30. The dose of sertraline was increased to 150 mg/day over 2 weeks and clonazepam 0.5 mg thrice daily was reinstituted. He was also referred for cognitive behavior therapy. Improvement was noticed gradually after a month.

DISCUSSION

This is an interesting case of two coexisting culture-bound syndromes along with OCD. Initial examination was not enough to detect the OCD spectrum as it was camouflaged with predominant complaints of Dhat and later Koro-like symptoms. He displayed Koro-like symptoms not classical Koro. The ongoing Koro epidemic at the background increased his vulnerability. It is interesting that both the culture-bound syndromes were related to genital organ and function. The association of Koro and Dhat has also been reported in the literature (2), and they found the role of peer pressure in the development of Dhat syndrome. Furthermore, in one report, there were some hints about the association of Koro with OCD spectrum (4) which focused “continual compulsion to manually pull” penis or ritualistic regular tying of the penis with cloth before sleep and another case (3) focused the thoughts of penile retraction as intrusive and repetitive, with obsessive doubts. Koro has been reclassified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition as under “other specified obsessive–compulsive and related disorders” (5). In view of these findings, the authors believe that all Koro and especially Koro-like cases (with subacute/chronic presentation) should be screened for OCD spectrum.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

Sayanti Ghosh, Arabinda Narayan Chowdhury

1
Letters to Editor

Associate Professor, Department of Psychiatry, NRS Medical College, Kolkata, West Bengal, India, ¹Psychiatrist, Leicestershire Partnership NHS Trust, Thurcaston, England, UK.
E-mail: dr_sayanti@rediffmail.com

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Sir,

Electroconvulsive therapy (ECT) is one of the lifesaving treatments for patients with various severe mental disorders.¹ The initial cardiovascular response to the electrical stimulus includes initial parasympathetic upsurge, lasting for 10–15 s, during which the patient is observed to have bradycardia, hypotension, and transient asystole. This is followed by a sympathetic upsurge, which peaks at 3–5 min after the electrical stimulation, during which patients may have increased blood pressure (BP), tachycardia, and cardiac arrhythmias.²-⁴ Occasional patients also develop sinus arrhythmias, atrial and ventricular premature beats, and minor ST-T changes during the postimmediate postelectrical stimulation.³ Sustained ventricular tachycardia (VT) is rarely reported during the ECT procedure, and the literature is limited to few case reports.⁵-⁸ Here, we report a 24-year-old female patient who had VT after three consecutive ECTs.

A 24-year-old female suffering from paranoid schizophrenia since the age of 20 years presented to inpatient unit following a suicidal attempt. Her mental state examination revealed the presence of delusion of reference and delusion of persecution, auditory and somatic hallucinations, made act and thought broadcast. The patient also reported that she made suicide attempt under the influence of commanding auditory hallucinations. In the inpatient unit, she was initially treated with risperidone up to 5 mg/day for 6 weeks, but she showed minimal improvement in psychotic symptoms. While on risperidone, she showed emergence of depressive symptoms and worsening in the intensity of commanding hallucination, asking her to harm herself. Following this, ECT was considered. Her pre-ECT evaluation did not reveal any abnormality in the hemogram, serum electrolytes, liver function test, renal function test, electrocardiogram (ECG), and X-ray chest posterior–anterior view. Her ECG showed a heart rate of 70 beats/min (BPM), which was regular, and there was no evidence of any arrhythmia. Routine monitoring of BP during the week before ECT showed readings of systolic BP to vary from 110 to 124 mmHg and diastolic BP to vary from 76 to 84 mmHg. During the first ECT, she was getting the same dose of risperidone, and no new medication was added. She was given ECT, with atropine as a premedication and thiopentone and succinylcholine as the inducing agents. Immediately, after the first ECT (receiving the electrical stimulus), her heart rate decreased to 48 BPM, and she required treatment with injection atropine 0.6 mg i/v. With this, her heart rate improved, but the patient developed monomorphic VT with hypotension (BP = 60/40 mmHg), which resolved spontaneously in 30 s, without any intervention. At this point, the possibility of atropine-induced VT was considered. Her heart rate and BP were monitored for the next 3 days, which did not reveal any abnormality. Following this, she was considered for second ECT during which atropine was avoided as...