the lesion, therefore, cannot be used as evidence of any cause and effect relationship to drug treatment. Fibroblastic reactions in other areas have been associated with the beta-blocker practolol,⁴ and psoriatic skin lesions and dry eyes have occurred after treatment with oxprenolol.⁵ But, so far as we know, retroperitoneal fibrosis has not been reported in association with oxprenolol. Retroperitoneal fibrosis is a serious condition which is easily overlooked. It has been reported in association with another beta-blocker, and it should be considered in any patient taking a beta-blocker who develops chronic impairment of renal function.

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(Accepted 2 October 1980)

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Homosexual behaviour after vasectomy

Vasectomy has become increasingly popular as a safe, simple, and reliable method of male sterilisation. In the absence of pre-existing marital and sexual problems and with the informed consent of both the husband and wife vasectomy generally has no adverse effects on the marital relationship.¹ We report the case of a patient whose sexual orientation changed after vasectomy.

Case report

A 32-year-old married man was seen at a clinic for sexual problems, at the request of his wife, nine months after he had had a vasectomy. Within six weeks of the operation he had experienced, for the first time in his life, homosexual feelings which had led him to embark on a sexual relationship with a man. In stable employment for the previous 12 years, he worked responsibly and was highly esteemed by his employers. He was a reserved, self-sufficient person with no history of psychiatric disturbance. The middle of three sons, he described a happy, secure childhood during which he could not recall any effeminate behaviour. He had developed an interest in girls during early adolescence and denied feeling anxious in female company. His first heterosexual relationship at the age of 15 had amounted only to petting, and during the ensuing 10 years he had enjoyed relationships with six other women. He had had no previous sexual deviation and throughout adolescence he had masturbated regularly with heterosexual fantasies. At 25 he had married a woman of similar age after a five-month courtship. Sexual activity occurred 8 to 10 times a week during the early years of marriage and was initiated by both partners. His sexual drive and erectile potency contributed to an active and fulfilling sexual life. After the birth of their second child the couple decided, after careful deliberation and by mutual consent, that a vasectomy would provide the most acceptable method of birth control.

Within six weeks of the operation his homosexual thoughts and fantasies began to emerge. His sexual interest in his wife declined to negligible levels. His masturbatory fantasies became exclusively homosexual and preoccupying and were not unpleasant or disagreeable. Three months after the operation he started a homosexual relationship. Homosexual activity occurred daily, the patient adopting both the active and passive roles in sexual acts with his partner. At no stage did he spontaneously request treatment to suppress his sexual behaviour. One year after vasectomy he continues to live with his wife but remains preoccupied with his homosexual partner.

Comment

There have been several reports of psychiatric and sexual problems after and apparently related to vasectomy.²⁻⁴ In one study three couples with no pre-existing sexual problems suffered serious physical sexual deterioration with complete impotence, vaginismus, and persistent premature ejaculation.³ Such reactions are rare and the

likelihood of their occurrence can be diminished by effective pre-operative counselling.⁴ A change in sexual orientation after vasectomy is exceedingly rare, and we are not aware of previous reports.

Although a causal connection between the vasectomy and the ensuing change in sexual orientation in our patient cannot be proved, the operation was probably the precipitating event in a predisposed person. The concept of latent or well-compensated homosexuality has been invoked to explain a type of person in whom homosexual feelings may be unconscious and whose homosexuality may come to light during times of stress.⁵ Had our patient not undergone vasectomy perhaps some other event would have served to make his "latent" homosexuality manifest. In any event, such an outcome could not have been predicted by a preoperative assessment. Indeed, it would have revealed a vigorously heterosexual and potent man with no previous experience of homosexual feelings or activities. He found his change in sexual orientation a rewarding experience and expressed no desire to alter it.

Requests for reprints should be addressed to Dr C M Bass.

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(Accepted 2 October 1980)

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Spontaneous disappearance of psoriasis as presenting feature of oat-cell carcinoma of lung

Oat-cell carcinoma of the lung and ectopic production of adrenocorticotrophic hormone is a well-recognised phenomenon.¹ We describe a patient whose initial "complaint" was spontaneous cure of lifelong psoriasis.

Case report

A 68-year-old woman was admitted to this hospital after referral from her general practitioner. Seven weeks before, and over 10 days, her lifelong and extensive psoriasis had completely disappeared. Since childhood she had had lesions on hands, elbows, knees, legs, trunk, and in her scalp, and for about the past 15 years she had given up trying to cure them with "messy creams." One week before admission she had had an episode of haemoptysis, and radiography had shown collapse of the right lower lobe. She had smoked 20 cigarettes a day all her adult life. On examination she looked Cushingoid, and there was no evidence of any psoriatic lesion. She had a collapsed right lower lobe and enlargement of the liver.

Bronchoscopy showed a friable tumour protruding up the right main bronchus, which on biopsy proved to be an oat-cell carcinoma of the lung. She had glycosuria and a fasting blood glucose concentration of 10 mmol/l (180 mg/100 ml). Full blood count was normal, erythrocyte sedimentation rate 16 mm in first hour, and measurement of urea and electrolyte concentrations disclosed hypokalaemic alkalosis (sodium 141 mmol(mEq)/l, potassium 2.9 mmol(mEq)/l, chloride 100 mmol(mEq)/l, carbon dioxide 32 mmol/l (14 ml/100 ml), urea 5.9 mmol/l (35.5 mg/100 ml), creatinine 87 μmol/l (1.0 mg/100 ml)). Twenty-four hour urinary free cortisol concentrations were raised on three occasions (mean 11.0 μmol/24 h (4.0 mg/24 h); our reference range 0.2-1.0 μmol/24 h (0.1-0.4 mg/24 h)). Plasma cortisol concentrations at 8 am and 12 midnight (our reference ranges 190-720 and <220 nmol/l (6.9-26.1 and <8.0 μg/100 ml) respectively) were 1680 and 1700 nmol/l (61.0 and 61.6 μg/100 ml) and diurnal rhythm was lost. Serum adrenocorticotrophic hormone concentration was 334 ng/l (our reference range 10-80 ng/l). Liver alkaline phosphatase activity was 530 IU/l (normal 90 IU/l) and liver scan confirmed multiple filling defects consistent with

metastases. She was aware of her diagnosis but declined further treatment and was discharged home.

Comment

This patient had clear evidence of ectopic adrenocorticotrophic hormone syndrome secondary to oat-cell carcinoma of lung. In association with this and as an initial feature she had a spontaneous cure of lifelong psoriasis. We think that these two events were related and can find no other reports of this unusual phenomenon. Just as the onset of certain skin lesions may herald an underlying neoplasm² before it is symptomatic, so may the disappearance of one, as in our case.

We are grateful to Mr W C Barnsley for permission to report this case.

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(Accepted 3 October 1980)

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Carbon monoxide poisoning secondary to inhaling methylene chloride

Carbon monoxide poisoning usually results from inhaling fumes from engine exhausts, poorly ventilated heating devices, or gas refrigerators. With the advent of natural gas, which is free of carbon monoxide, the risk of accidental poisoning has decreased. We report a case of severe carbon monoxide intoxication caused by inhaling methylene chloride from a commercial paint remover.

Case report

A 20-year-old art student developed nausea and severe, throbbing headache while using a commercial paint remover in a poorly ventilated, unheated room. About an hour later she left the room, feeling dizzy and unwell, and shortly afterwards lost consciousness. She was admitted to the casualty department conscious but disorientated in time and space. She was distinctly flushed with cherry-red colouring of skin and mucosae. Radial pulse was 98/min, and blood pressure 120/70 mm Hg. Cardiovascular system, respiratory system, and abdomen were normal. Haemoglobin concentration was 13.7 g/dl, and white blood cell count $7.3 \times 10^9/l$ ($7300/mm^3$; normal differential). Carboxyhaemoglobin concentration on admission was 50%. Chest radiograph and electrocardiogram were normal.

This patient's symptoms were surprisingly mild for the strikingly high carboxyhaemoglobin concentrations. She was treated with 60% oxygen 4l/min, and after 12 hours the carboxyhaemoglobin concentration was 20%. She was discharged from hospital on the third day.

Comment

Using a paint remover containing methylene chloride in an enclosed room may lead to a large amount of the solvent being absorbed with prompt metabolism to carbon monoxide and a consequent increase in blood carboxyhaemoglobin concentration.¹⁻³ Methylene chloride is released slowly from body tissues, resulting in carbon monoxide remaining in the circulation for a prolonged period.⁴ Hence the carboxyhaemoglobin concentration after inhaling methylene chloride remains high longer than after inhaling carbon monoxide.

Carbon monoxide poisoning is a serious hazard to patients with coronary artery disease, since only marginal increments in carboxyhaemoglobin concentration necessitate greatly increased coronary

blood flow to prevent ischaemia.⁵ Though our patient responded to 60% oxygen, higher concentrations (ideally 100%) are mandatory, especially in a patient with coronary artery disease.

Methylene chloride is present in several paint removers, and any patient with coronary artery disease likely to be exposed to this agent should be warned.

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(Accepted 7 October 1980)

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Value of routine chest radiography of psychiatric patients

Chest radiography is often performed routinely on patients admitted to psychiatric wards; at one time it was mandatory. A chest radiograph costs about £12.50 (May 1980), and our radiology department suggested that reducing "routine" requests for radiography need not prejudice patient care. Some consultant psychiatrists, however, maintained that chest films were necessary to exclude unsuspected physical disease that might be responsible for psychiatric symptoms. We therefore decided to survey the results of chest radiography of patients admitted to our 60 acute psychiatric beds to find how often unexpected disease was reported.

Method and results

We examined the daily records of the x-ray department for the names of acute psychiatric inpatients who had had chest radiography during 21 May 1979 to 31 March 1980. If an abnormality had been reported we referred to the request form for the patient's age and clinical details, and film and report were then reviewed by a consultant radiologist.

The 746 admissions during the period generated 231 chest x-ray examinations. Twenty-one of these (9%) were reported as showing a "significant" abnormality (broadly defined by us as warranting further investigation or treatment)—namely, active tuberculosis (two cases), other infective changes (seven), abnormal masses (five), cardiac enlargement (five), generalised emphysema (one), and fractured ribs (one). Sixteen of the 21 patients had chest symptoms or signs mentioned on the request card, two had confusional states, and five had a diagnosis of alcoholism. None had "functional" psychiatric conditions without physical symptoms or signs. (A table giving details of these 21 cases is available on request.) Twenty-five other reports mentioned abnormalities of no current clinical relevance, mostly old inactive tuberculosis.

Comment

No chest radiograph disclosed an abnormality entirely unsuspected clinically. Most patients with significant x-ray abnormalities had chest symptoms or a diagnosis of alcoholism. Alcoholism is well known for its association with physical disease, and the two cases of active tuberculosis were in alcoholics. Routine chest x-ray examination may be thought necessary before electric convulsion therapy, for medico-legal reasons, though Abramczuk and Rose¹ found that it did not add appreciably to information obtained from the history and physical examination.

We conclude that chest radiography need not be performed on