Higher qualifications extended me to the full, and beyond. Then came the army, where the comradeship carried me along with little to worry about. Being a consultant with the prestige that went with it greatly helped in the environment of hospital practice, but there were still the social handicaps in the trivia of conversation. The speaking problems that to the “normal” person are so trivial as to be unnoticed are to me the frightening obstacles, whereas a big problem may well seem a molehill instead. This has been proved so often by the ease with which I have talked to patients and colleagues, only to be floored soon after by having to ask for something in a shop or answer the telephone.

Now that I can look back from the haven of retirement it is possible to make certain comments on this strange and baffling impediment. Yes, it would have been nice not to have to contend with this frustrating and embarrassing condition. It still is most frustrating and embarrassing. My friends tell me that it is much less so to others than it is to me, but I still have to contend with the desire to retire into a shell. There are many ways in which people who stammer can be helped, but the one way above all others is to give us complete attention while we concentrate all our efforts on the verbal steeplechase that lies ahead. To make a snatch at a difficult word and to experience the pleasant surprise of clearing the hurdle, only to find that your addressee was not listening, is made worse by the major disaster as you crash at the fence on the second attempt. We all learn by experience, and there are many ways of circumventing or overcoming obstacles. There are numerous alternative words, or

even quaint phrases, which may sound strange to others but all help in this strange hurdle race of conversation.

I have some regrets, now seen more clearly with hindsight. If only all of us as children could start off under the care of a paediatrician who regards stammering as a symptom rather than a diagnosis. We as children in my time were at the mercy of a diversity of therapists, each confident that his method was sure to succeed if you followed the course with application. If you were not cured then it was your fault; you can speak perfectly well when alone, so it is psychological, it is yourself that is at fault. I am sure that this is a cause of much unhappiness to a lot of children.

The more I experience it the more I am sure that there is a neurological basis for this strange and yet ill understood malady. To suggest that it is due to some Freudian complex, or a subtle way of avoiding something that we do not like, or the result of some far distant event in infancy, is just not good enough. Please, as doctors, take us and our problem seriously and do not farm us out in strange pastures. Looking back now on a lifetime of this handicap, in which I have known no other, it would have been nice to be without it. It warps you in certain ways, cramps you in some of the social aspects of life, and even causes some misery at times. Having said all this, I consider my life to have been interesting and challenging and even to have had its funny side, and it has gained me many many friends. Strange as it may seem, I would not now have had it otherwise.

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Clinical Topics

Sexual dysfunction in Asian couples

DINESH BHUGRA, CHRISTINE CORDLE

No information is available on the prevalence of sexual dysfunction in Asian couples in the United Kingdom. There are only two papers concerned with Asians out of over 2000 papers published on sexual dysfunction between 1966 and 1985.^{1,2} This study looks at 32 Asian couples who presented to a sexual dysfunction clinic between 1977 and 1983. The drop out rate was high, with lower than generally reported success, and we consider some of the factors that may have been responsible.

Present study and results

The sexual dysfunction clinic at Leicester General Hospital covers the inner city population, which includes some 60 000 Asians; many of these speak Gujarati, Punjabi, Urdu, and Hindi. Referrals are accepted from general practitioners, psychiatrists, physicians, surgeons, and social workers.

The details of all 23 men and nine women with Asian names referred to the

clinic from 1977 to 1983 were retrieved from the referral register. The table shows the presenting symptoms. In at least four couples there were problems in both partners but only the presenting partner's complaint was taken into account. In the men the duration of symptoms ranged from six months to 25 years, and 17 men (73.9%) had had their problem longer than five years. By contrast, the duration of the women's symptoms varied from one to five years. At least nine of the men and two women had initially attended for screening seeking medication and somatic explanations for their problems. Five or more men and two women also had language difficulties.

Of all 32 patients, 14 (43.8%) gave up attending the clinic; some left immediately after screening and others dropped out during treatment. At least four patients dropped out because they or their partners had gone to the Indian subcontinent for a long holiday.

Of the 18 couples taken on for treatment, five (27.7%) reported an improvement.

Presenting symptoms in 32 Asians (23 men, nine women) attending sexual dysfunction clinic

	No (%) of men	No (%) of women
Premature ejaculation	14 (60.9)	6 (66.7)
Secondary erectile dysfunction	14 (60.9)	7 (77.8)
Delayed ejaculation	1 (4.3)	1 (11.1)
Primary erectile dysfunction	6 (26.1)	0
Low drive	5 (21.7)	0
Others:		
Sexual identity	1 (4.3)	
Urethral discharge	1 (4.3)	
Dyspareunia		
Lack of interest		
Primary anorgasmia		
Secondary anorgasmia		

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Discussion

One of us (DB) joined the clinic in 1982 with a special interest in sexual dysfunction among Asian couples, and since then the referral rates of Asians have risen substantially.

The high preponderance of men with problems contrasts with Bancroft and Coles's data on white patients, which showed an equal sex ratio.³ One explanation may be that Asian women are generally more passive, less demanding, and have different expectations. There were proportionally more single men than women and a substantial minority of married men presented alone.

Our success rate is lower than generally reported. The poor results may be due to several factors, such as language difficulties, cultural expectations, seeking of organic explanations, and poor motivation. These are considered separately. Some problems are caused by poor education, yet it is difficult to suggest reading material as there is very little on sex and sexual dysfunction in Asian languages. During the clinic sessions translations are only partial, selective, and are difficult to understand. In joint sessions the wife usually sits quietly contributing very little even after repeated encouragement. At least one wife insisted on speaking only through her husband. Thus only a few patients gain any information. We are currently preparing a simple handbook in Hindi, which we hope will be translated into other languages.

Cultural expectations affect attitudes to sex. Hinduism and Islamism are described as sex positive religions but they have become strict.⁴ For Indian men the loss of "vital fluids" (semen) is important in their development and growth. Carstairs noted the teaching which says "[semen] takes 40 days and 40 drops of blood to make one drop of semen... [which] is ultimately stored in a reservoir in the head... semen of good quality is rich and viscous, like the cream of unadulterated milk. A man who possesses a store of such good semen becomes a superman."⁵ Kulanayagam states that these views are prevalent even today.⁶ Demerdash and colleagues found that explanations of male sexual inadequacy vary from supernatural causes (among Kuwaiti patients) to masturbation (among Palestinian patients).^{7,9}

Social expectations emphasise procreation, and the couples are encouraged to have children as early as possible. Nag points out that when families share a house there may be little privacy and opportunity for sex and "performance anxiety" might be expected.¹⁰

Cole reported that many couples show considerable resistance to

pleasuring,¹¹ which is exaggerated in Asian couples when sex is regarded as procreative.¹² One couple in the series admitted that their sexual contact was always in the dark, always at night, only in their bed, without any foreplay or any variation in the position, and when they were fully clothed. This illustrates Ahmed's statement that Indian men perform sex out of duty for eternal salvation, at night, and only with their wives.¹² The wife must accept sex in whatever quantity and quality the man delivers. Many Asians seem to insist on an organic explanation for the dysfunction; this adds to the frustration of therapists—and patients. Kodagada states that Asian adolescent boys attribute their vague somatic symptoms to loss of semen.¹

Successful treatment depends on motivation. Cole states that British couples are less motivated than American.¹¹ Asian couples seem to have even less motivation. If the woman wants treatment and the man does not the outcome is poor, but if the man is highly motivated he may encourage his partner more.

Our study was retrospective and its small size makes any conclusions tentative. A larger, prospective study is planned.

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A patient has just separated from her husband to go and live with another man in his early 30s whose wife died quite recently at the age of 29 from cancer of the cervix. What risk is there of her developing cervical cancer?

The patient's risk of developing cervical cancer depends partly on her own reproductive history, the major factors being her age at first coitus, and the number of her sexual partners.^{1,2} A woman is at higher risk if she smokes or comes from a low socioeconomic group, and at particularly high risk if she has had venereal disease or has worked as a prostitute.^{1,3} If this patient's husband has a job that means frequent absence from home she has a higher chance of developing cancer of the cervix, presumably because such jobs increase the chance of extramarital coitus.³ Her risk is related to the number of her husband's sexual partners,¹ and is particularly high if he has had recourse to prostitutes.² These risk factors also apply to her new partner, whose lifestyle may have had a bearing on the fact that his first wife contracted the disease. Since 1973 there has been an American study of the wives of men whose previous wives developed cervical cancer, and so far in this group there have been 2.7 times the expected number of cervical cancers.⁴ Although this might suggest that by moving in with her new partner this woman may almost triple her risk, the American study did not control for all risk factors, and for this woman the epidemiological damage may already be done. Because of this uncertainty I do not think it would be right to warn her of a possible risk from her new liaison, but she should of course have regular cervical smears.—JAMES OWEN DRIFE, senior lecturer in obstetrics and gynaecology, Leicester.

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Does exposure of hospital personnel to cancer chemotherapeutic agents pose a health risk?

Many of the compounds used as cancer chemotherapeutic agents are toxic and present a potential hazard to pharmacy, medical, and nursing staff concerned with their preparation, reconstitution, administration, and disposal. This is especially true of alkylating agents, which may cause direct chemical burns of the skin, eyes, and mucous membranes. Longer term risks are less clear but since most anticancer agents are mutagenic and many are known to be carcinogenic¹ they must be handled with care. Preparation and handling of these drugs is a specialised task that requires training, careful supervision, and appropriate facilities. I am not aware of any cases of cancer which can be attributed to inadvertent exposure to anticancer agents during normal clinical practice. Indeed, such evidence would be hard to obtain. Falck and colleagues reported that a group of nurses responsible for handling cytotoxic drugs provided positive results when assayed for urinary mutagens.² The importance of these observations is, however, in doubt—such mutagenic activity is, for example, detectable in the urine of cigarette smokers.—G CURRIE, director, cancer research institute, Oxted.

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