

Brief Research Communication

Hypochondriasis: Clinical Profile in a Tertiary Care Psychiatry and Neurosciences Hospital in Southern India – A Retrospective Chart Review

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ABSTRACT

Background: Hypochondriasis is a complex disorder in the realm of psychosomatic medicine, yet understudied in India. The aim of this study was to assess the clinical profile of patients diagnosed with hypochondriasis. **Materials and Methods:** Retrospective chart review was done in a tertiary care psychiatry and neurosciences hospital in southern India. Medical records of adults diagnosed with hypochondriasis between 2000 and 2010 were analyzed. These patients were also re-diagnosed retrospectively using Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for illness anxiety disorder (IAD) and Diagnostic Criteria for Psychosomatic Research (DCPR) criteria for health anxiety and illness phobia. Data were organized and analyzed using PSPP for descriptive statistics of different variables. **Results:** There were 114 patients with hypochondriasis, with the most common belief being about dysmorphic appearance. Selective serotonin reuptake inhibitors (SSRIs) were the most commonly prescribed medications. The median follow-up duration was only 2 months. Five percent of the cases fulfilled the criteria for DCPR health anxiety and 20.4% for DCPR illness phobia. DSM-5 criteria for IAD were fulfilled by 45.6% of the cases. **Conclusion:** Dysmorphic appearance was the most common concern in patients with hypochondriasis and SSRIs the most common medications. The follow-up rate and the diagnostic concurrence with DSM-5 IAD and DCPR were low. Studies assessing the influence of psychopathology and culture on the presentation, course, and prognosis of hypochondriasis would be beneficial.

Key words: Health anxiety, hypochondriacal disorder, hypochondriasis, illness anxiety, illness phobia
Key messages: a) This study found that dysmorphic appearance was the most common concern in subjects with hypochondriasis. b) The follow up rates and diagnostic concurrence with DSM % Illness anxiety disorder was low.

INTRODUCTION


Hypochondriasis is a unique disorder with the primary feature of persistent preoccupation with the

possibility of having one or more serious and progressive physical disorders [International Classification of

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Diseases, 10th Edition (ICD-10)]. It is categorized under somatoform disorders in ICD-10 and DSM-4. Body dysmorphic disorder too is subsumed under hypochondriacal disorder in ICD-10.^[1] DSM-5 includes hypochondriasis under somatic symptom and related disorders and subcategorizes it into somatic symptom disorder and illness anxiety disorder (IAD).^[2] The prevalence of hypochondriasis is reported to be between 0.02% and 7% in general population studies and between 0.8% and 8.5% in primary care studies.^[3] The variation in the prevalence rates is due to the difference in the settings and variability in the criteria for the diagnosis.

Demographic variables, namely, socioeconomic status, educational level, race, or sex, have been inconsistently reported to be associated with hypochondriasis.^[3-7] The course of hypochondriasis is generally chronic, with persistent symptoms reported in 34%–70% of patients.^[8,9] The maximum duration of follow-up found by these studies was around 5 years.^[10] Hypochondriasis is also noted to have an association with anxiety and depression, yet the psychiatric comorbidity may not influence its course.^[3,8]

The literature on hypochondriasis is scant from developing countries like India.^[11-14] This study aimed to assess the clinical profile of hypochondriasis in an Indian psychiatric hospital setting. This will add to the current understanding on this complex disorder and encourage further research.

MATERIALS AND METHODS

The study was conducted in the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore. The hospital register was accessed for the number of patients who had received a diagnosis of hypochondriacal disorder (hypochondriasis) as per ICD-10 clinical descriptions and diagnostic guidelines, for the duration between January 2000 and December 2010, that is, a period of 11 years. The files of adult patients (age above 18 years) diagnosed with hypochondriacal disorder and having symptoms for more than 1 month were retrieved and assessed for adequacy of data. The files with adequate data were used for data extraction using a semi-structured proforma. The details extracted from the files included sociodemographic details such as age, gender, socioeconomic status, religion, residence, and marital status.

The clinical details collected included presence and details of precipitating factor, type of onset, duration of illness, perceived illness or organ system involved, personal and family history of psychiatric illness, personal and family history of medical illness, treatment

received by the patient, duration of follow-up, and presence of referrals to other medical specialties. The cases were re-diagnosed as per the Diagnostic Criteria for Psychosomatic Research categories of illness phobia and health anxiety and the DSM-5 category of IAD.^[2,15] The data collected from the medical records were organized and analyzed using PSPP.^[16] This study was approved by the Institutional Ethics Committee.

RESULTS

Sociodemographic variables

There were 124 patients with the diagnosis of hypochondriasis as per the medical register. Ten patients were excluded after reviewing the medical records, due to lack of adequate information or a revised diagnosis. Hence, the total number of adult patients diagnosed with hypochondriacal disorder as per ICD-10 clinical descriptions and diagnostic guidelines from January 2000 to December 2010 (11 years) was 114. Among these, 86 (75.4%) were men and 28 (24.6%) were women. The age at presentation varied between 17 and 64 years, and the mean age was 33 ± 11.47 years. Seventy-six (68%) patients belonged to an urban background. The majority of the patients [97 (85%)] were Hindus, and 52 (46%) were married. The mean year of education was 12.09 ± 4.80 years.

Clinical variables

The duration of illness at presentation varied between 1 and 240 months, with a mean of 50.22 ± 49.56 months and a median of 36 months. The most common type of onset was insidious, noted in 91 (79.7%) cases. The presence of precipitating factor was reported by 57 (50%) cases. The presence of a precipitating factor was twice more common in men (56.98%) than in women (28.57%). Inpatient care was received by 30 (26.3%) of the cases. The most common hypochondriacal beliefs were about dysmorphic appearance (26.3%), HIV/AIDS (12.3%), brain diseases (11.4%), and cancer (10.5%). Among the cases having belief about dysmorphic appearance, 22 (75%) had beliefs related to facial appearance [Table 1].

Overall, psychiatric comorbidity was noted in 64 (56.1%) cases, with comorbid depression and anxiety disorders being present in 31 (27.2%) and 32 (28.1%) cases, respectively, and the proportion was similar in both the genders. History of medical illness was reported by 29 (25.4%) of the cases, and it was more common in men (30.23%) when compared with women (10.71%). Family history suggestive of anxiety disorders was present in 10 (8.8%) cases. The most commonly prescribed medications were selective serotonin reuptake inhibitors (SSRIs; 77%). Among them, escitalopram, which was prescribed

Table 1: Clinical and treatment related variables

Variable	No. (%)
Clinical variables	
Onset	
Abrupt or acute	25 (20.3)
Insidious	89 (79.7)
Perceived illness/organ involvement	
Appearance	30 (26.31)
HIV/AIDS	14 (12.28)
Brain diseases	13 (11.40)
Cardiac diseases	11 (9.64)
Cancer	12 (10.52)
Gastrointestinal illnesses	10 (8.77)
Others	27 (23.68)
Psychiatric comorbidity	
Any psychiatric illness	64 (56.1)
Depressive disorder	31 (27.2)
Anxiety disorders	32 (28.1)
Diagnostic concurrence with DSM-5 IAD	
Present	52 (45.6)
Absent	62 (54.4)
DCPR concurrence	
Health anxiety	6 (5.30)
Illness phobia	23 (20.16)
Treatment-related variables	
Type of treatment	
Inpatient	30 (26.3)
Outpatient	84 (73.7)
Medications used	
SSRIs	85 (74.56)
SNRIs	11 (9.64)
TCAs	12 (10.52)
Antipsychotics	23 (20.16)
Benzodiazepines	14 (12.28)
Behavior therapy received	
Yes	37 (32.5)
No	77 (67.5)
Referrals to other specialities	
Yes	18 (15.8)
No	96 (84.2)
Duration of follow-up	
No follow-up	39 (34.2)
Up to 6 months	39 (34.2)
7-24 months	20 (17.5)
More than 24 months	16 (14.0)

DSM-5 – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, IAD – Illness anxiety disorder, DCPR – Diagnostic Criteria for Psychosomatic Research, SSRIs – Selective serotonin reuptake inhibitors, SNRIs – Selective norepinephrine reuptake inhibitors, TCAs – Tricyclic antidepressants

in 43 (50.58%) patients, was the most commonly used SSRI. Cognitive behavior therapy was received by 37 (32.5%) cases, and 18 (15.8%) cases were referred to other medical specialities. The follow-up duration ranged from 0 to 108 months, with a mean of 10.58 ± 20.23 months and a median of 2 months. When the Diagnostic Criteria for Psychosomatic Research (DCPR) was applied retrospectively, 6 (5.3%) cases fulfilled the criteria for health anxiety and 23 (20.4%) for illness phobia. Fifty-two (45.6%) cases fulfilled the DSM-5 criteria for IAD.

DISCUSSION

In the 11-year period, only 114 patients received a diagnosis of hypochondriasis in the hospital which has around 10,000–12,000 new psychiatric patient registrations yearly (as per the annual reports), which is suggestive of a low prevalence in this setting. The possible reasons could be that patients with hypochondriasis are more likely to seek other specialists like plastic surgeons, physicians, or neurologists based on their beliefs and are unlikely to seek psychiatric help on their own.

We found a higher proportion of men (75.4%) in our sample, whereas earlier studies have conflicting results about the gender preponderance of hypochondriasis.^[7] The mean duration of illness at presentation was above 4 years (50 months), suggesting the chronicity of the illness and also a poor understanding about the illness. The presence of a precipitating factor was reported by half of the cases (more commonly by men than women), suggesting a possible role of environmental or modifiable factors in the onset of the illness.

The most common hypochondriacal beliefs were about dysmorphic appearance, followed by brain-related diseases, and HIV/AIDS. We are not aware of any pattern of types of hypochondriacal beliefs noted in other studies.

The overall psychiatric comorbidity was 56%, which is high and comparable to earlier reports of 62%–64.9%.^[17,18] One-fourth of the cases had a history of medical illness which may have contributed to the development of health anxiety and hypochondriasis. Cognitive behavior therapy was received by 32.5% of the cases. This low rate may be attributed to patient preference as well as availability and logistic issues. The median follow-up duration was only 2 months, suggestive of poor compliance. Data about the degree of improvement noticed in follow-up were not available consistently and hence could not be assessed.

The diagnostic concurrence of these cases with DSM-5 IAD was around 45%, DCPR illness phobia was 20%, and DCPR health anxiety was 5%, suggesting the differences in the various diagnostic systems, which can have treatment and research implications. The low concordance rates with DSM-5 IAD could be due to the fact that patients with a dysmorphic appearance as core beliefs are likely to receive a diagnosis of body dysmorphic disorders, which is a separate category in DSM. With ICD-11 making changes in the status of hypochondriasis and new criteria in DSM-5 and DCPR, the diagnostic concept of hypochondriasis has been changed to an extent.

The strengths of this study are the long duration of data assessed, the study of different clinical variables including phenomenological and treatment-related variables, and assessment of concurrence with DSM-5 and DCPR criteria. The limitations are the retrospective design, hospital-based data, and data based on medical records. Using minimum 1 month symptoms as duration criterion which is insufficient as per the diagnostic criteria for research given by ICD-10 (the study used criteria given in ICD-10 clinical descriptions and diagnostic guidelines) and the lack of structured assessment of the subjects are other limitations.^[1,19] Further studies on clinical manifestation and course, which are prospective and involve different clinical settings and assess cultural influences, would be helpful in a better understanding and management of hypochondriasis. Studies assessing the relation of psychopathology with the course and prognosis would also be beneficial.

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Conflicts of interest

There are no conflicts of interest.

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