

MONOSYMPTOMATIC HYPOCHONDRIACAL PSYCHOSIS—2 CASE REPORTS

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SUMMARY

Two patients with monosymptomatic hypochondriacal psychosis are reported and the condition is briefly discussed.

Monosymptomatic Hypochondriacal Psychosis (MHP) is an uncommon disorder characterised by a single delusional system with hypochondriacal content. These conditions differ from others with hypochondriacal symptoms in the degree of reality impairment. While hypochondriacs are often aware that their fear of illness is groundless, in MPH the delusions are fixed and unarguable. The delusion is not secondary to another psychotic illness and the personality is otherwise well preserved.

MHP occurs at any age from adolescence onwards, affects the sexes equally, and has a very poor prognosis without treatment. Its presentation is relatively independent of cultural factors. A past or family history of psychotic illness is very uncommon. However, substance abuse and/or head injury in younger patients, the ageing brain in older patients and long standing personality problems may be of aetiological importance. Generally considered a rare entity, MHP may be underdiagnosed as they present to dermatologists, plastic surgeons and medical specialists more readily than to psychiatrists (Munro, 1988).

According to the content the delusions fall into three main groups :

- (a) Delusions of body odour or halitosis.
- (b) Infestation delusions (insects, burrowing worms or foreign bodies under the skin).
- (c) Delusions of ugliness of misshapeness (dysmorphic delusions).

Within the delusional systems, the patient shows marked illogicality, insisting against all evidence, on a physical etiology, going to many physicians, surgeons or dermatologists and even initiating strange 'cures' of his own. Though paranoid anger is not uncommon, secondary depression, shame and avoidant behaviour are more frequent. The disorder causes great anguish and sometimes suicide. Folie a deux is relatively common (Munro, 1988).

Case Reports

Case 1 : An illiterate retired soldier aged 70 years, being treated by the dermatologist for the past 8 months for itchiness of the skin, was referred for psychiatric evaluation as there was no organic cause for his complaints. Patient complained of itchiness all over the body due to infestation with tiny, dark coloured parasites which burrowed into his skin. He presented evidence in the form of skin flakes. He said that though the parasites were killed by the medicines, they continued to live in his clothes, resulting in reinfestation. He therefore requested that medicines be given not

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only for local application, but also for his clothes.

He was the youngest of 5 siblings of a poor rural family. There was no past or family history of neuropsychiatric illness. Patient had undergone cataractomy of left eye 4 years back after which, due to some complications, his left eye was enucleated. After retirement he made his living by tending to cattle. He was married and had 2 daughters, who were also married. There was no marital disharmony. He smoked 2-3 bidis per day. He denied habituation to alcohol or drugs.

Physical examination revealed immature cataract of right eye. Psychiatrically he was well-kempt and cooperative. Talk was relevant and coherent. He was extremely anxious, worried and mildly depressed with delusions of infestations in a clear sensorium. He lacked insight into his delusion and had initial insomnia. Relevant investigations including hemogram, urinalysis, blood sugar, liver function tests, VDRL, skull radiograph and fundoscopy were normal. He was initially treated with tab. trifluoperazine 30 mg daily in divided doses for one month with no response. He was then put on pimozide 4 mg once daily to which he responded rapidly. His anxiety and depression reduced markedly and his sleep normalised. He was no longer preoccupied with his delusions. After 6 months pimozide was gradually tapered off. On follow up after one year there was no relapse.

Case 2 : A 52 year old male, educated upto VI class, was referred to psychiatrist with the complaint that an insect had burrowed into his head through his left ear. History revealed that 3 years back patient had suffered from suppurative otitis media of left ear with purulent discharge for which he was treated by the

ENT specialist. Gradually patient began to complain that an insect had burrowed into his head through his left ear and he could feel its movements. After the ear was declared to have healed completely by the ENT surgeon, patient consulted many general practitioners, ENT specialists, ayurvedic and homeopathic doctors and faith healers, but despite all the treatments his complaints persisted. He even presented evidence of the infestation in the form of dried ear wax which he had stored in a match box.

He was the second of 6 sibs from a poor rural family. There was no past or family history of neuropsychiatric illness. He was married and had 4 issues. There was no marital disharmony or stress in the work sphere. He smoked one bundle of bidi/day, but denied habituation to alcohol or drugs.

Physical examination was normal. Mental status examination showed a well-kempt and cooperative individual, talking relevantly and coherently, who was extremely preoccupied with his illness. He was anxious, agitated and mildly depressed with delusions of parasitosis in a clear sensorium. He lacked insight into his delusions. Relevant investigations including hemogram, urineanalysis, blood sugar, liver function tests, VDRL, skull radiograph and fundoscopy were within normal limits. He was treated with pimozide 8 mg daily to which he responded gradually. His anxiety and depression became less and he was no longer preoccupied with his delusions.

Discussion

Till recently MHP was considered untreatable. However, at present pimozide, a highly specific dopamine blocker, appears to be the most specific treatment and can be dramatically effective in doses of 2-12 mg. There are a few reports of cures

with other neuroleptics, like fluspiroline, and tricyclic antidepressants, but, in general these seem to be less effective than pimozide (Pylko and Sicignan, 1985; Munro, 1988; Fernando, 1988). A single case report claimed an excellent result with amoxapine, currently perhaps the most antidopaminergic of the antidepressant drugs (Tollefson, 1985).

The efficiency of pimozide in MHP has led to the speculation that if in schizophrenia there is a complex breakdown of the interactive functions of dopaminergic, noradrenergic, serotonergic and even other neurotransmitter systems, is it possible that in a circumscribed delusional disorder such as MHP there may be a circumscribed neurotransmitter dysfunction affecting only the dopaminergic system (Reily, 1988). Some patients with MHP develop clinically significant post-psychotic depression while on pimozide. Since these patients have no previous history of effective illness, a possible marginal overlap with affective disorders has been postulated (Munro, 1987). In addition, there is evidence that erotomania and paranoid jealousy are very similar to MHP, except as regards the delusional content and that they too may respond to pimozide (Munro, 1984;

Munro et al., 1985). As the treatment of delusional disorder in general is not very satisfactory, it is possible that pimozide may be effective, not only in MHP, but in delusional disorders in general.

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