MONOSYMPTOMATIC HYPOCHONDRIACAL PSYCHOSIS A REPORT OF 3 CASES

S G Kong
K H Tan

Department of Psychological Medicine
National University of Singapore
College Road
Singapore 0316

S G Kong, MBBS, DPM, MRCPsych
Lecturer

Woodbridge Hospital
Yio Chu Kang Road
Singapore 1954

K H Tan, MBBS, DPM
Registrar

SYNOPSIS

Three cases of monosymptomatic hypochondriacal psychosis were described and discussed. Attention was drawn to their main clinical features, namely a single delusional belief without other psychotic symptoms. All three cases responded well to phenothiazines. The fact that these conditions tend to present as secondary depression or at the door of other discipline were highlighted.

INTRODUCITON

Monosymptomatic Hypochondriacal Psychosis (MHP) is a condition not usually described in English textbooks of Psychiatry and rarely diagnosed in Singapore. As a disease entity, it was initially described by German and Scandinavian psychiatrists and later crystallised into a unitary concept. Delusional psychosis has traditionally been associated with paranoid states and paranoid schizophrenia (1, 2) although some authorities linked it with depressive illness (3). In 1978, a leader in the British Medical Journal (4) highlighted the distinction between MHP and its neurotic equivalent, dysmorphophobia, while at the same time, an American psychiatrist (5) was agonising over the lack of reference to these two conditions in the American literature. The present status of monosymptomatic hypochondriacal psychosis is still uncertain, but the diagnosis appear to be gaining acceptance. This is reflected in the fact that while ICD-9 (6) has no provision for the diagnosis, the American DSM-III classified it under the rubric "Atypical Psychosis" (7).

In this paper, we present three cases of diagnosed monosymptomatic hypochondriacal psychosis and discuss their clinical features.

CASE REPORTS

Case 1

PY, male, 72 years, first presented as a referral from a dermatologist with a diagnosis of Dermatitis Artefacta. He had been treated without relief for about one year and admitted twice for inpatient treatment of a persistent itch and blistering which started after he was bitten on his lips by red ants. This resulted in an itch, scratching and consequent blistering. Since then, he complained of ants hiding at the back of his head and coming out at night to cause the itch. He also complained of poison coming out of his eyes. His personal history indicated that he was born in China, the 4th of 5 siblings. Coming to Singapore at the age of 17 years, he worked as a seaman until his retirement about 6 years ago. There is no family history of mental illness. He did not have a history of smoking, drinking or other substance abuse. When examined psychiatrically, he was well orientated and his speech was relevant and rational. No delusion or hallucination was elicited except for the unusual belief about his skin condition. He expressed worry about it, but did not seem depressed. Physical examination was normal except for multiple sores and excoriation from head to foot. A diagnosis of a delusional psychosis was made.

Treatment was instituted with trifluoperazine 5 mg tds and benzhexol 2 mg tds. Two weeks later, there was marked improvement, with good healing of the skin, except for a slight itch over the scalp. Four months later, he was referred back by the dermatologist for similar complaints. Treatment was recommenced with trifluoperazine and he again improved. He subsequently defaulted treatment three times and each time he had to be remedicated to relieve his symptoms. He is still on follow-up.

Case 2

TAF, female, 20-year old Chinese girl, first presented in August 1981 with a 3-year history of change of personality. She was reported to be short-tempered, withdrawn and irresponsible, keeping late nights and borrowing money heavily from friends. She also could not get along with family members and friends, and had threatened suicide thrice. A diagnosis of probable early schizophrenia was made. She defaulted follow-up.

She was then admitted 4 months later for attempting to set fire on herself following a quarrel with her boyfriend. Her clinical state at that time was observed to be tearful and depressed. No delusion or hallucination was elicited. She was at this time thought to have a personality disorder. She again defaulted follow-up.

She came back another 4 months later with complaints of feeling uncomfortable, unable to concentrate and "an image of an unpleasant look" troubling her. She attributed this "unpleasant-look" to her facial features, which had been bothering her since the age of 15 when her problems first begun. Because of this disturbing image of what she took to be her face, she had reconstructive surgery done to her nose, chin and then her eyes over a period of one year. Each time surgery was requested for what she perceived to be unpleasant and unsightly facial features and after each surgery she would be pleased for a while, but would again complained about her ugliness soon after. After four operative procedures, the plastic surgeon became suspicious and thought a psychiatric assessment indicated. In the light of this complaint, she was re-evaluated and diagnosed as a case of monosymptomatic hypochondriacal psychosis.

In her family history, she is the youngest of 6 siblings. Her father is deceased, while a paternal uncle had died of suicide by hanging. Her personal history was uneventful. After her father's death at the age of 15 years, she began to manifest behavioural and psychological problems. Her academic performance which was previously rated as good deteriorated rapidly. She then left school and was unemployed for 2 years and later did odd jobs with each job lasting 2-3 days.

After her diagnosis, she was treated with pimozide 2 mg daily increasing to 6 mg daily. An EEG was ordered which was reported as normal. Significant improvement was seen and her complaints were relieved, but the medication had to be reduced later because of side effects. She was then switched to trifluoperazine 5 mg tds. Nine months after treatment she was noted to be depressed. Treatment was continued, but she defaulted eleven months after she started treatment. She was never seen again.

Case 3

CHT, male, 25 years, presented with a history of depression for one month. He was depressed at his place of work and complained that his colleagues had been avoiding him because of his body odour. He claimed that he was emitting a foul odour inspite of repeated cleansing although family members could detect no odour from him. Because of this odour, he concluded that he must be passing out urine unconsciously or else there would not be any odour about him.

He was greatly affected by it to the extent that one day, unable to tolerate the smell and the avoidance of his colleagues, he returned home and locked himself in. He was found unconscious 2 hours later on the floor by his family who took him to hospital. No treatment was given, but he was investigated for possible causes of this "bad odour". He was also referred for psychiatric assessment.

On evaluation, there appeared to be no significant contributory factor in his family and personal history. He is the youngest of 16 siblings and is employed as a technician. Medically there is a past history of infective hepatitis which was treated and from which he recovered. Before induction into National Service, he was found to be hypertensive but this was not treated as it was fairly stable at 160/80 and labile. There is no history of substance abuse. Physically his build is on the obese side.

Clinically, he was noted to be withdrawn and depressed. He spoke in low tones. Except for the unusual belief about his body odour, there were no other delusions or hallucinations. He also reported insomnia, weight loss and cried at times because of his perceived problems.

Laboratory investigations carried out showed a normal blood profile. Urea and electrolytes were within normal limits. ESR was estimated at 3 mm per hour. Skull and chest X-rays were clear and a lumbar puncture revealed no abnormality. An EEG done was also within normal limits. An MMPI assessment showed evidence of depression with a paranoid tendency.

He was treated with trifluoperazine 5 mg tds. There was rapid response to treatment. He however defaulted follow-up. Two months later, he came back complaining of a mild recurrence of symptoms and was again treated with trifluoperazine. About 10

weeks after treatment was initiated, the patient stopped all medication as symptoms were relieved. A review 6 months later indicated that he was well. There was no relapse since.

DISCUSSION

Monosymptomatic hypochondriacal psychosis can be very diverse in their clinical presentation as in the three cases here. The first case is essentially a delusion of skin infestation. This led to abnormal skin sensation and a compulsion to scratch and excoriate. Descriptively this is similar to Ekbom's description (8) and share the features of other skin delusions described (9).

The second is a dysmorphic delusion about a bodily part namely the belief that the face is mishapen and therefore ugly. It is in this case that the distinction between dysmorphophobia and MHP becomes important. But this is unlikely to be a case of dysmorphophobia as her face does not exhibit any prominent features. Moreover her belief is a vague delusion — her face is mishapen and ugly. She decided in turn that this ugliness must be her nose, chin and her eyes. The fact that she responded to neuroleptics would serve to support the clinical diagnosis (10).

The last is a case of an olfactory delusion which is fairly typical of what Pryse-Philips (3) described. According to Pryse-Philips, when the olfactory delusion is accompanied by other symptoms it tended to be a case of schizophrenia, whereas the monosymptomatic condition is more likely to be neurotic or delusional in nature. He noted that reactive depression commonly occur in monosymptomatic cases, as in this case.

In all 3 cases it is important to note that organic causes, particularly neurological causes, could well account for the symptom and so it was necessary that organic causes be excluded, hence the various investigations.

The precipitating factor in the first case was an actual occurrence of a biting episode, while the second appeared to be precipitated by a life event, namely the death of the father. The third seems more insidious, with no obvious precipitant and the patient only gradually became aware of the symptom. In the last 2 cases there were accompanying reactive depression. In the second case, there is a positive family history and difficulty in relationship with others was also noted. In the third, he felt that others were avoiding him and this paranoid symptom though prominent is probably secondary to the main symptom.

The age of MHP patients at presentation varies from 20 to 80 years with more females in the older age group. The sex incidence is equal. Average age quoted for female patients is 61.8 years and for male patients is 39.5 years (9). In this regard, the ages of 2 of our cases are much younger, with a male, 25 years and a female, 20 years. Our first case of a 72 year-old male seems more typical.

All the 3 cases were successfully treated with trifluoperazine, a departure from the accepted formulation which states that MHP responded specifically to pimozide (9, 10). The second case was indeed treated with pimozide but switched to trifluoperazine because of side effects. Pimozide is related in chemical structure to haloperidol, and in chemical activity to both haloperidol and trifluoperazine. Of more relevance may be the evidence of similarity between pimozide and trifluoperazine in their side effects profile (11). We conclude therefore that MHP do respond to other neuroleptics other than pimozide and that the difference may be one of relative efficacy than specificity.

The course of the disease in all these 3 cases is varied. In Case 1, there was good recovery after 4 months, but requires continued follow-up. Case 2 unfortunately defaulted, while Case 3 after an initial relapse, recovered completely without medication after 3 months. This is quite in agreement with what is described in the literature (9), with remission occuring within a week of medication and follow-up ranging from six months to four and a half year.

It is to be noted that before the symptoms completely remit, any spontaneous cessation of medication would result in a return of symptoms as in all 3 cases. Drug treatment may not be the only treatment available, as Beary and Cobb (12) have described behavioural treatment for three cases of monosymptomatic delusion of alimentary stench. In these cases, however, it is unclear whether they are indeed delusional psychoses as the diagnostic criteria is suspect.

Coming to the question of diagnosis and terminology, is Monosymptomatic Hypochondriacal Psychosis a clinically well-defined condition? It appears to be so, but there are difficulties. There is no doubt that some cases could possibly progress to depression or to schizophrenia. The relationship to paranoid states and to delusional conditions like paranoid jealousy cannot fail to escape our attention. But in cases which do indeed become schizophrenic there will be without fail, various hallucinations or delusions or some other symptoms. MHP by themselves do not give rise to other symptoms besides the presenting delusion. At most because of the distress to the patient, a secondary reactive depression may occur, as in case 3, which presented as a case of depression and a suicidal risk. More relevant though is the distinction between dysmorphophobia and MHP. Reference has been made to the fact that dysmorphophobia is the neurotic equivalent of MHP. Case reports and descriptions of MHP and dysmorphophobia indicate a certain degree of overlap (10, 13, 14). Cases of dysmorphophobia (13) were recommended to have a trial of treatment with pimozide. Although this was suggested as a diagnostic test, one cannot help but note that phenomenologically, the distinction between the two is difficult. Disturbances of personality are often cited as supportive of a diagnosis of dysmorphophobia, (14) while the same personality disturbances are said to occur in some cases of MHP (9). Again, dysmorphophobia has also been linked with psychotic depression, (14) so that the differentiation is ultimately dependent on the clinical judgement of whether the symptom is neurotic or psychotic. Granted the considerable degree of overlap there is no doubt that there is a neurotic condition in which there is an abnormal overvalued idea about the body not amounting to a delusion, and a psychotic condition in which there is a delusional psychosis. It would be wise in the interest of scientific progress to consider the two conditions as phenomenologically separate.

While MHP is uncommon, it is not necessarily rare as in a year, it may be possible to see about 1 case or so (15). Unfortunately, they tend to present at the door of other disciplines. Cases of delusional psychosis involving the skin tend to be seen by a dermatologist, dysmorphic delusions by a plastic surgeon, olfactory delusions by a neurologist and so on. Only when they are recognized as delusional are they seen by a psychiatrist.

In conclusion, it would seem that MHP is probably more common than supposed. The diagnosis is

seldom made because of the lack of a distinct diagnostic criteria and until recently an unknown diagnosis. The fact the MHP is frequently seen by non-psychiatric disciplines is a contributing factor. They could also present at a psychiatric clinic as cases of depression. It would thus be beneficial to both clinicians and patients alike that cases of MHP be identified early and correctly treated.

ACKNOWLEDGEMENTS

We wish to record our thanks to Dr S.H. Teo for permission to use the cases, to Assoc Prof W.F. Tsoi for advice and criticism and to Miss W.C. Lim for typing the manuscript.

REFERENCES

1. Kenyon FE: Hypochondriacal States. Brit J of Psychiatry 1976; 129:1-14.
2. Retterstol N: Paranoid Psychoses with Hypochondriac Delusions as the main Delusion. Acta Psychiat Scand 1968; 44:334-53.
3. Pryse-Phillips W: An Olfactory Reference Syndrome. Acta Psychiat Scand 1971; 47:484-509.
4. Editorial: Dysmorphophobia. British Medical Journal 1978; 2:588.
5. Andreasen NC: Correspondence. American Journal of Psychiatry 1977; 134:1313-4.
6. World Health Organization. Mental Disorders: Glossary and Gender to their Classification in accordance with the Ninth Revision of the International Classification of Diseases (ICD-9). Geneva: 1978 (WHO).
7. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders 3rd Edition. (DSM III) Washington: 1980 (APA).
8. Ekbom KA: Der Prasenile Deermatozoenwahn. Acta Psychiat et Neurologica Scand 1938; 13:227-39.
9. Munro A: Monosymptomatic Hypochondriacal Psychosis. Brit J of Hosp Med 1980; 24:34-8.
10. Riding J, Munro A: Pimozide in the Treatment of Monosymptomatic Hypochondriacal Psychoses. Acta Psychiat Scand 1975; 52:23-30.
11. Janssen PAJ, Van Bever WFM: Structure-Activity Relationships of the Butyrophenones and Diphenylbutylpiperidines. In: Iversen LL, Iversen SD, Snyder SH eds. Handbook of Psychopharmacology Vol 10. New York: Plenum Press 1978: 1-31.
12. Beary MD, Cobb JP: Solitary psychosis — Three cases of Monosymptomatic Delusion of Alimentary Stench treated with Behavioural Psychotherapy. Brit J of Psychiatry 1981; 138:64-6.
13. Braddock LE: Dysmorphophobia in Adolescence — A case Report. Brit J of Psychiatry 1982; 140-199-201.
14. Hardy GE: Body Image Disturbance in Dysmorphophobia. Brit J of Psychiatry 1982; 141:181-5.
15. Tsoi WF: Personal Communication. 1983.