

## MONOSYMPTOMATIC HYPOCHONDRIACAL DELUSION AND ITS DIFFERENTIATION FROM DHAT'S SYNDROME, DEPRESSION AND SCHIZOPHRENIA - A CASE REPORT

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### ABSTRACT

#### BACKGROUND

Monosymptomatic Hypochondriacal Psychosis (MHP) is a form of obsessive compulsive spectrum disorder characterised by the single delusional belief that there is a serious problem in the skin or other body parts. Because MHP patients believe that their illness is physical, not psychiatric, they usually consult several other medical specialists before attending Psychiatry Clinic and often referred by other Speciality Department. This leads to different time-consuming examinations and treatment interventions. In this case report, we emphasise the importance of diagnosing the illness correctly and referring the patient to a psychiatrist. The patient presented in this report has been treated with a new generation antipsychotic and anti-obsessive drug. This treatment has led to significant improvement. Therefore, we conclude that MHP is a psychiatric illness, which needs early diagnosis and psychiatric treatment.

#### KEYWORDS

Hypochondriasis, Delusion, Antipsychotics.

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#### BACKGROUND

Historically, the term Monosymptomatic Hypochondriacal Psychosis (MHP) was first used by Munro in 1978.<sup>[1]</sup> MHP is classified as a somatic type of delusional disorder in DSM-V and is defined as an erroneous conviction of bodily disease, abnormality or alteration.<sup>[2]</sup> It includes delusional beliefs about bodily sensations or functions such as feeling malodorous, being infected by parasites, having body dysmorphic features or that a certain organ is no longer functioning.<sup>[3]</sup> A solitary delusional belief of this type, often bizarre, lies at the core of the disorder referred to as Monosymptomatic Hypochondriacal Psychosis (MHP). The term 'monosymptomatic' does not imply the absence of symptoms of psychiatric disability other than the central delusion; merely that such symptoms if present are not part of the primary psychotic illness, but represent a psychogenic reaction to it.<sup>[2,4-7]</sup> In fact secondary non-psychotic phenomena such as anxiety symptoms, minor depressive features, phobic avoidance behaviour and compulsive actions are frequent accompaniments to MHP. MHP appears to have no predilection for any particular age, sex, racial or religious grouping.<sup>[8]</sup> Consistent clinical characteristics of MHP include the longstanding, persistent nature of the central complaint, the absolute belief with which it is maintained and acted upon and the total lack of insight into its delusional nature.

The disorder neither remits spontaneously nor progresses to further delusional elaboration or the development of additional psychotic perceptual disturbances. Personality disintegration does not occur.

#### Case Report

Mr. P, a 21-year-old, unmarried male patient of urban background and poor socio-economic status presented to psychiatry outdoor along with his father with complaints of low mood, decreased interest to live, irritable aggressive behaviour at times (Usually while looking himself in mirror), poor self-care and personal hygiene. The patient told that he tried to end his life multiple times by ingesting rat poison; sharp blades, etc., but no history of any such event or any history of hospitalisation due to such event was given by patient's attendant. On further enquiry, patient told that for past 6 - 7 years he has been having the complaint of frequent nocturnal emissions and passage of white mucous discharge before and during urination. He says that all his sufferings started after this only and since then he is becoming weaker and weaker ("chehra sukhta jaraha hai, haddiya gal rahi hain"). He keeps roaming here and there in his home, but feels no desire to go outside because of his poor self-image. On explaining that his condition is not due to the nocturnal emissions, patient becomes irritable and does not listen at all. He is very firm in his belief that all his sufferings are due to these nocturnal emissions and passage of whitish discharge in urine. He is educated up to 6th standard and is 2nd in birth order with 1 elder sister and 1 younger brother and sister. There is no history of any drug abuse. There is no past or family psychiatric illness. He has taken treatment from different local hakims and some quacks also with no improvement at all in his condition. He appears to be well cooperative during interview with an anxious affect and becomes irritable only when his belief is contradicted. His routine investigations including CBC, ESR, Urinalysis and CT

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(Brain) came out to be normal. On the basis of above history and mental state examination, differential diagnoses of sexual neurosis - Dhat syndrome, Schizophrenia, Hypochondriacal delusion and Depression with psychotic features were put forth. The firmness with which the belief was held despite repeated proof and persuasion excluded the Dhat syndrome. Schizophrenia was ruled out because of absence of first rank symptoms and other diagnostic features other than that of somatic delusion. As low mood and poor self-image were secondary to his belief of passage of semen in urine, a primary diagnosis of depression could not be formulated. Finally, diagnosis of monosymptomatic hypochondriacal psychosis was made according to DSM-V. Patient was started on Risperidone 1 mg and Fluoxetine 20 mg per day. On subsequent followup after one month, patient showed improvement and his dose was increased to Risperidone 2 mg and Fluoxetine 40 mg per day. The patient is maintaining well after 3 months with the same medications. He has started going out, his irritability has decreased and he is now more receptive towards suggestions.

### DISCUSSION

MHP appears to have no predilection for any particular age, sex, racial or religious grouping,<sup>[8]</sup> social class or intellectual level. This impression correlates with the findings of Lucas et al<sup>[9]</sup> with respect to hypochondriacal delusions in schizophrenia. Obsessional personality traits<sup>[10]</sup> and relative social isolation are more frequent companions of MHP than chance alone would permit, as is the apparent absence of any specific pattern of familial illness. In our case also, response with antipsychotic along with anti-obsession drug (Fluoxetine) also goes in its favour. Psychotherapeutic techniques and physical methods of treatment have little influence on the disorder, as is evident by the total lack of insight in our patient into the delusional nature of this disorder. Thus our case clearly highlights the need for correct and timely intervention in such cases and the role of biological therapy in the management of such patients.

### CONCLUSION

Symptoms in monosymptomatic hypochondriacal psychosis because of their similarity with other psychiatric illnesses present a difficulty in its diagnosis. In our case the response with anti-obsessive and antipsychotic drugs highlights the importance of timely and correct diagnosis in the management of this disorder.

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