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Monosymptomatic Hypochondriacal Psychosis

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DSM-IIIR (American Psychiatric Association, 1987) has revised the Kraepelinian concept of paranoia, but has given it the name of delusional (paranoid) disorder. The description is of an encapsulated, monodelusional disorder with several subtypes as follows: Erotomanic, Grandiose, Jealous, Persecutory, Somatic, Unspecified.

Kraepelin described the first four of these and considered that a hypochondriacal form might also exist (Kraepelin, 1921). When I first saw a case of monosymptomatic hypochondriacal psychosis (MHP) in 1971, I was not aware of the condition because the English language literature had all but suppressed Kraepelin's description of monodelusional disorders, and any mention of a hypochondriacal form was obscure.

In 1975 Dr Erik Strömgren put me in touch with the small Scandinavian and German literature on MHP. Having seen several cases by that time I was glad to find that this mysterious condition had been described and given a name, which I adopted.

The literature of that time agreed that MHP was essentially untreatable, but in 1975 I had evidence of six cases successfully treated with pimozide – five of my own and one of Dr Terence Reilly's. This encouraged me to continue my search for more cases and to try the effect of pimozide on them. I tried to institute a double-blind comparison with chlorpromazine but had to abandon this because of the patients' uncooperativeness. So I went on collecting and treating non-blindly, until I could derive a general description of MHP.

A growing literature agrees that MHP often improves with neuroleptics, especially pimozide and fluspirilene (Hamann & Avnstorp, 1982; Ungvari & Vladar 1984; Reilly *et al*, 1978) and also indicates that the condition is not rare. Most deluded hypochondriacal patients go to somatic specialists, not psychiatrists, and dermatologists in particular have long been aware of infestation delusions. The dermatologists have welcomed the diagnosis of MHP and treatment with pimozide (Lyell, 1983; Sneddon, 1983); however, they are not always aware of the detailed psychiatric differential diagnosis. Delusional hypochondriasis is the primary presentation in MHP, but may be secondary to severe depressive disorder, schizophrenia and paraphrenia, organic brain disorder, both chronic and acute, and substance abuse (Skott, 1978).

Obviously one has to be sure of diagnosis to be sure of treatment, and these illnesses have to be excluded before MHP can be diagnosed with confidence; but MHP is not just a diagnosis by exclusion, and there is now a firm enough description to allow one to say it is an illness *sui generis*, and to make a diagnosis on positive grounds.

I will describe the characteristics of the disorder based on my own series of approximately 70 cases, 50 of which I have published (Munro, 1982). Recent descriptions by other authors agree well with the features I shall mention.

MHP – the illness presentation

In my description of 50 cases, I noted that the patients fell into three main groups according to the content of the delusion:

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

In each case, the complaint was advanced with great intensity and the patient was totally convinced of the physical nature of the disorder, despite all evidence to the contrary. Especially in the infestation cases, 'evidence' was often presented, usually in the form of skin flakes in a pill bottle or a matchbox (Leading Article, *The Lancet*, 1983). The encapsulated nature of the disorder is very noticeable: the patient's way of life is taken over by an unremitting search for 'cure' (always on their terms), but if their conversation can be diverted to other topics, they temporarily become much more rational, and apparently less hyperalert. In 60% of my cases, patients 'saw' or 'smelt' abnormalities and could not be dissuaded from this. While many may have delusional misperceptions or illusions, some appear truly hallucinated. Nearly all patients appeared anxious and overalerted; severe insomnia was present in 60%.

Only 28% showed profound paranoid anger and suspiciousness, which is the stereotype we have of such patients. Secondary dejection, often severe, was present in 64%, and profound shame was a feature in 80%: the illness is seen by the patient as socially disgusting, and they may have fears of contaminating others or of arousing disgust in others, which leads

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them to avoid social contact. Several patients (14%) – all with infestation delusions – had approached civic authorities or pest control agencies with requests for disinfestation, sometimes repeatedly.

I was often the first psychiatrist to see these patients (and most resented being referred to a psychiatrist). The average time-gap between first onset of the condition and the time of my first consultation was 4.1 years in males and 6.2 years in females (range 1 month to 40 years). Meantime, increasing attendance on physicians had been almost universal. When I first saw them, the majority of patients were attending two or more physicians, and the majority had had multiple physical investigations and treatments. Usually the delusional nature of the complaint went unrecognised for a considerable time, and about a quarter of the patients expressed great anger about medical incompetence, complaints which were as often justified as paranoid.

Sooner or later, the psychiatric nature of the condition is recognised and 58% of my patients had previously been given psychotropic drugs, especially benzodiazepines, phenothiazines, haloperidol or tricyclic antidepressants. Sometimes these reduced the degree of preoccupation, or the intensity of delusion, but the complaint never vanished. In my series, males and females were almost equally represented (23:27) but there was a tendency for the psychiatric background to be recognised somewhat earlier in males, suggesting that they are more overtly disturbed and more difficult to handle.

Sixty-two per cent of patients said that the onset was insidious; the rest said it was sudden and often in relation to some life stress. Once established, the complaint might fluctuate in intensity but otherwise was unremitting. As a general rule, the specific complaint remains constant, but the patient's demands for treatment tend to escalate. Thirty-four per cent of patients had initiated treatments of their own, ranging from strange diets to cauterisation of the skin to get rid of parasites, none of which had worked. Despite this, they were reluctant to discontinue these 'treatments'.

These patients experience profound disturbance of their lives as a result of the illness. Its chronicity, the tension it generates, the endless quest for unavailing treatments and the conflicting and inappropriate advice they are given, cause enormous anguish to them and their families. The more distressed and delusional they become, the more frantically they seek the wrong kind of help and the more antagonistic they become towards psychiatric help. The literature suggests that some may eventually commit suicide: 26% of my patients admitted to suicidal thoughts related to their delusions and four individuals had made previous suicide attempts, one a very serious one.

The age of onset ranged from adolescence to extreme old age. It was my impression that delusions of ugliness perhaps appeared earlier than other hypochondriacal delusions. In my group of 50 patients, there were nine associated cases of *folie à deux (or trois)*. When the primary patient's condition was successfully treated, the symptoms of the secondary cases appeared to resolve spontaneously. (Incidentally, interest in this topic, aroused by these cases, has also led to changes in the description of Shared Delusional Disorder in DSM–IIIR). Despite the literature suggesting that deafness and paranoia are linked, I found clinical deafness in only one patient, an elderly man.

Psychiatric background

Prior to the onset of their delusions, 34% of the patients had had contact with psychiatrists, almost always for personality problems or, in the case of three males, for alcoholism. None admitted to previous psychotic episodes.

Substance abuse was admitted by 32%; these were mostly males. In 24% there was evidence of some form of brain insult at some time. In all, 40% had a history of alcohol and/or drug abuse and/or possible minor brain damage. Many of my younger patients had had brain insults and my older patients had, of course, elderly brains. I suspect there may be an aetiological factor of importance here. Five of 23 males (i.e. 22%) were considered to be homosexual: only one of 27 women appeared to be lesbian.

Family history

Thirty per cent of patients reported psychiatric conditions in close relatives, usually parents or siblings, but the impression was that schizophrenic and paranoid illnesses were not common; this concurs with recent evidence about the low frequency of psychotic illness in the relatives of paranoid patients (Kendler *et al*, 1985; Watt, 1985).

Demographic background of patients

Among 50 patients, 13 nationalities or races were included. Males tended to cluster in the younger age groups and females in the older, with some overlap. In my series, the lower social classes were over-represented: this may be an artefact of my practice or may indicate that more sophisticated MHP

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patients are cleverer at avoiding psychiatric referral. I have no evidence to suggest that the illness frequently causes downward social drift.

The patients themselves report longstanding personality problems in a high proportion of cases. Many seem excessively introverted, and the males often have a history of substance abuse and a poor work record. There is a high frequency of celibacy and separation/divorce. Of 23 males, average age 38, only one was married at the time of first interview, 16 had never married, four were separated and two were widowed. Of the entire group, 44% had never married and 24% were divorced or separated. Among those who were married, the reproduction rate was strikingly low. The overall impression is that the premorbid personalities are, in many instances, strikingly incompetent.

Treatment

Four patients refused treatment, proffering very irrational excuses, and three other patients almost certainly did not comply. The remainder were treated with pimozide. The regimen is simple. The drug is best given in a single morning dose: if taken later it may cause insomnia in some patients. Conversely a few patients report drowsiness and prefer to take it at night. The daily dose usually lies in the range of 2–12 mg, most frequently 2–6 mg, but higher doses have been reported. I usually prefer to start with a low dose and increase gradually over about a week. While marked improvement is usually noticeable within 2 weeks, delays of up to several months in amelioration of the delusion have been noted in a few cases.

Treatment outcome

Of the 43 patients who complied, 32 were judged to have an excellent result, with return to full function and total or near-total remission of symptoms. Nine patients had partial remission, with significant reduction of anguish and reasonable social adjustment – i.e. 82% of 50 patients had excellent or partial recovery in a condition traditionally regarded as untreatable. However, to achieve compliance, great tact and perseverance are often required.

Only four patients had marked neurological side-effects from pimozide, and I had the impression that previous substance abuse or brain insult was significant here. The side-effects usually responded well to benzhexol. On the other hand, the clinical outcome with pimozide as regards the MHP itself seemed to be independent of the presence or absence of previous substance abuse or head injury. Mean length of follow-up was close to 1 year (range 1–48 months). Some patients can be withdrawn gradually from pimozide but my impression is that the majority require maintenance treatment. Sometimes those doing well without pimozide will report a minor recurrence of symptoms at times of emotional stress. Most patients, however good their recovery, continue to insist on a physical aetiology for their delusional symptoms.

Six patients had clinically significant post-psychotic depression while on pimozide. This is an area of some interest in itself since, so far as I could discover, none of the patients had any previous history of affective illness. It is one reason why I speculate as to a possible marginal overlap with affective disorder (Munro, 1987).

Summary

In brief, therefore, we are dealing with an illness characterised by a single delusional system – in this instance with hypochondriacal content – which can occur at any age from late adolescence onwards, appears to affect the sexes equally, and has a very poor prognosis without treatment. Its presentation appears to be relatively independent of cultural factors. A previous history, or a family history, of psychotic illness seems very uncommon. However, substance abuse and/or head injury seem to be background factors in a high proportion of younger patients and I would speculate about the role of the ageing brain in the more elderly patients.

Within the delusional system, the patient shows marked illogicality insisting, against all evidence, on a physical aetiology, going to many physicians, and initiating strange 'cures' of his own. Although paranoid anger is not uncommonly a feature, secondary depression, shame and avoidant behaviour are more frequent. The illness causes great anguish, and sometimes suicide. *Folie à deux* is relatively common. At present, pimozide appears to be the most specific treatment and can be dramatically effective. There are scattered reports of improvement or even cure with other neuroleptics or tricyclic antidepressants but, in general, these seem less effective than pimozide (Cashman & Pollock, 1983; Brotman & Jenike, 1984; Pylko & Sicignan, 1985). However, a single case report recently from the USA is intriguing: an apparently excellent result with amoxapine, currently perhaps the most antidopaminergic of the antidepressant drugs (Tollefson, 1985). However, although the case description is suggestive of MHP, the author regards it as one of major depressive illness.

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Finally, I have gathered some 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).

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