

Monosymptomatic Hypochondriacal Psychosis (somatic delusional disorder): A report of two cases

Historically, the term Monosymptomatic Hypochondriacal Psychosis (MHP) was first used by Munro in 1978.¹ MHP is classified as a somatic type of delusional disorder in DSM- IV² and is defined as an erroneous conviction of bodily disease, abnormality or alteration.³ It includes delusional beliefs about bodily sensations or functions; such as feeling malodorous, being infected by parasites, having dysmorphic features, or that a certain organ is no longer functioning.⁴ MHP has been divided into 4 main categories: Delusions of infestation (including parasitosis); delusions of dysmorphophobia, such as of misshapeness, personal ugliness, or exaggerated size of body parts (this seems closest to that of body dysmorphic disorder); delusions of foul body odours or halitosis or delusional bromosis (also known as olfactory reference syndrome); and a miscellaneous group.⁵

The term "monosymptomatic" does not imply the absence of symptoms of psychiatric disability other than the central delusion, rather that such symptoms occur as a psychological reaction to, or as a co-morbid disorder with, the primary psychotic or physical illness.^{3,6-9} The following two cases of MHP are presented to illustrate the psychosocial impact of the disorder, the treatment outcome, and to create awareness about this disorder among health care providers. The two patients gave informed consent for anonymous publication.

Miss A, a 29 year old single woman, presented with a year long history of third person auditory hallucinations, talking and laughing to herself, delusions of reference and a five month history of olfactory hallucinations of bad odour coming from her body and mouth and decline in personal hygiene. She withdrew from social activities, avoided interaction with people (including immediate family members), and stopped attending work. She became sad and wished herself dead but never attempted suicide and had no other symptoms suggestive of depressive illness. Her parents sought help from a traditional healer, visited two secondary health facilities, including a dental centre and the general out-patient department of our hospital from where she was referred to the psychiatrists.

This was her first episode but there was a history of mental illness in her maternal and paternal family. She was a university graduate and her inability to secure better employment (she was a primary school teacher) four years after her graduation was identified as a major psychosocial stressor that could have precipitated her illness. She was not

abusing any psychoactive substances and was said to be well adjusted pre-morbidly. Based on history and examination, she was managed as a case of paranoid schizophrenia (with olfactory reference syndrome) and was treated with haloperidol 15mg daily to which she responded positively after one week. As of when she was seen last in the out-patient clinic, she remained stable on maintenance dose of haloperidol 5mg nocte.

Mr B was a 45 year old married, Christian saw-miller who presented with a year and a half history of the feeling that insects were crawling all over his body, a mucus substance entering his eyes and a three month history of inadequate sleep. The insects were of different sizes and shapes (cuboidal and cylindrical). These insects produced different sensations and were more concentrated on the trunk and the pubic region. He believed that the crawling sensation was a sign that he had contracted Human Immunodeficiency Virus / Acquired immune Deficiency Syndrome (HIV/AIDS) because his symptoms started a month after he had sexual intercourse with a female friend. Following this, he stopped having sexual intercourse with his wife because he did not want to transfer the HIV/AIDS infection to her.

There were associated feelings of undue sadness, anhedonia, lack of energy, feelings of worthlessness and hopelessness, suicidal ideation (but no attempt), loss of appetite and poor sleep. He had stopped working because the noise from his machine made the insects more virulent. He had no perceptual abnormalities, other delusions or manic symptoms. He sought traditional help before consulting a physician who conducted numerous investigations, which were all negative, and referred him to the psychiatrists. This was his first episode of mental illness and there was no significant family history.

He was managed as a case of severe depression with psychotic features and delusions of insect infestation as a co-morbid disorder. He was treated on an out-patient basis with Amitriptyline and Trifluoperazine. Eleven months after his initial presentation, he was brought by his neighbours on account of poor medication adherence, lack of improvement in his health and serious suicidal intent. He was admitted for one month and had six doses of electroconvulsive therapy (ECT), cognitive and supportive psychotherapy, and oral medication. He had improved on discharge but a few months later, he defaulted for a year to attempt a religious cure. When he resumed treatment, his condition had deteriorated and his medication was changed to a combination of sertraline and trifluoperazine with minimal improvement. Amitriptyline was recommenced for financial reasons. Despite improvement in

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sleep and suicidal ideation, the crawling sensation of insects on his body persists.

The sociodemographic variables of the two cases are consistent with previous reports that MHP has no predilection for any particular age, sex, racial or religious grouping, social class or intellectual level.³ It has been documented that when MHP occurs, it should be considered as a co-morbid condition or psychological reaction to a psychiatric or physical illness.^{3,6-9} Patients have a tendency to self medicate or seek help from non-psychiatric sources. They come to the attention of the psychiatric services only by referral from colleagues in other specialities. This also accounts for the apparent under estimation of MHP prevalence in the general population.³ Treatment response in the two described cases was very different, according to the literature, treatment outcome depends on the underlying aetiology, type of treatment, patient compliance, age of onset and chronicity of illness.^{6,10} Slow response of patients to treatment is a common finding.⁶

The two cases highlight that MHP can occur in response to, or co-morbid with, a primary psychotic or physical disorder, that it has significant psychosocial impact and causes considerable morbidity and it may not be as rare as presumed.

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Self-inflicted bilateral orchidectomy precipitated by erotic bizarre delusions: a case report

Deliberate Self-harm (DSH) is defined as the intentional, direct injuring of the body tissue without suicidal intent.¹ The degree of harm or injury, be it isolated or repetitive, may vary from mild to very severe.² Deliberate self-harm is a behavior which may arise in a variety of psychiatric illnesses such as depression, schizophrenia, alcohol use disorders, and personality disorders. DSH patients with psychiatric illness have a high risk of committing repeated acts of DSH.³ The following is a report of a patient with schizophrenia, substance misuse and persistent ambivalence towards sexual activity who serially removed his testes, an act largely prompted by bizarre erotic delusions during psychotic relapses.

Mr. C, a 25 year- old male trader, presented at the emergency unit having removed his testis with a razor blade. After surgical repair by the urology team, he was referred to the psychiatric unit for further evaluation. Permission for publication of the case material was obtained from the Ekiti State University Teaching Hospital Ethics and Research Committee.

His reason for cutting through his scrotum with a razor blade and removing his right testis was that he observed a decline in his business fortunes whenever he ejaculated, following either masturbation or sexual intercourse. He believed ejaculating often weakened his supernatural power that enabled him to make any football club of his choice have a winning streak in the English Premiership League. He cited instances of drops in the ratings of his favourite clubs due to his uncontrollable sexual urge and associated ejaculation. He decided to remove his testes which he referred to as "the culprits". He specifically

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pleaded to have his left testis removed as well to "fulfill all righteousness".

Twenty-one months earlier, he had voluntarily presented at the psychiatric unit requesting his testes to be removed because he was afraid of impregnating a woman. He admitted feelings of guilt following sexual contact with women but did not entertain suicidal thoughts in relation to the guilt feelings. He declined admission and was managed on an out-patient basis with antipsychotic medication (Haloperidol 7.5mg daily). In spite of the treatment, he was insistent and desirous of his "main request" to have his testes removed. He defaulted treatment after a few weeks of attending the out-patient clinic.

The patient is the eldest of five children and did not enjoy a cordial relationship with his parents due to his rebellious and aggressive nature. He had to drop out of secondary education due to poor performance and truancy. He had no regular friends and preferred doing things his own way.

At 18 years old he experienced feelings of guilt following his first sexual experience with a 15 year old girl. Subsequently, he frequently patronized commercial sex workers and masturbated when he could not visit brothels.

He started smoking marijuana at age 12 years. He took alcohol regularly with opioid analgesics which he claimed often relieved him of his sexual urges.

Mental state examination, following self-orchidectomy, revealed a sturdily built young man who was not in any obvious distress in spite of the self-inflicted wound. His speech was irrational, though coherent. He showed no concern at removing his own testis. He admitted hearing strange voices rebuking him for his act. He believed people had knowledge of his unspoken inner mind. His judgment and insight were impaired considering his earnest desire to have his other testis removed. He, however, had to be transferred to another psychiatric facility, on request by his parents, due to the proximity of the facility to the family's place of abode.

Mr. C, however, reappeared 7 months later. Antipsychotic medication was continued. He defaulted, again, for 7 weeks, and was brought into the accident and emergency unit of the hospital, once more, on account of having completed removal of the second testis.

The case of self castration by a young man, with apparent sexual guilt, is an unusual occurrence. Whilst a pre-morbid

personality disorder has been noted as a risk factor in genital self mutilation (GSM)⁴, the act of GSM has been associated with psychosis.⁵ Psychosis in this patient could have been drug-induced as indicated by his drug and alcohol history. Intoxication could have influenced the patient's self castration with associated lack of concern for his act.

The patient had no insight and was insensitive to the pain that might be associated with his act which is in keeping with Grossman.⁶

Aboseif et al observed psychotic patients were at risk of repeating their acts of self mutilation as occurred in this patient.⁷ Deliberate self-harm patients can be non-compliant and difficult to engage in therapy.⁸ Crawford and Wessely noted that willingness of patients to engage with interventions, following DSH, is a key issue, as those less willing to take up the offer of services are more likely to repeat self harm.⁹ Poor treatment compliance was an additional issue that could have precipitated the second act.

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