Hypochondriacal delusion in an elderly woman recovers quickly with electroconvulsive therapy

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Abstract

A 72-year-old woman without any medical and psychiatric history, suffered from nausea, pain in the epigastria and constipation for over a year. She eventually lost 20 kilograms despite nightly drip-feeding. Extensive additional tests did not reveal any clues for her complaints. She remained convinced that her symptoms were a side-effect of anti-fungal medication she used. She was diagnosed with hypochondria. In the course of time her ideas about her somatic symptoms became delusional and she was diagnosed with a hypochondriacal delusion as part of melancholia, without depressed mood or loss of interest or pleasure as prominent features. It is important to recognize melancholia as soon as possible by continually evaluating other symptoms of depression. This may enable to avoid repetitive and exhaustive somatic examinations, which are not indicated, and to start effective treatment. In our patient electroconvulsive therapy resulted in a fast and complete recovery.

Introduction

Medically unexplained symptoms are frequent, 20-50% of symptoms presented to a general practitioner remain without a physical diagnosis.[1] Most symptoms vanish over time but a small percentage persists without a somatic explanation despite extensive additional tests. Epidemiologic research shows that 2.5% of the general population suffers from chronic somatic unexplained symptoms and in the elderly this is 3.8%.[2] A systematic review of the literature showed that approximately 50-75% of patients with medically unexplained symptoms improve, whereas 10-30% of patients deteriorate.[3] Especially in the elderly unexplained somatic symptoms are problematic since minor abnormalities in physical examination and work-up are frequently found without explaining the symptoms in a satisfying way. This may lead to underscoring of psychiatric diagnoses such as somatization disorder and hypochondriasis in elderly patients.

In this report, we describe a woman with a hypochondriacal delusion who doesn't meet the criteria for a severe mood disorder, somatization disorder or hypochondriasis according to the Diagnostic Statistical Manuel (DSM) IV-TR criteria.[4] Eventually she was diagnosed with melancholia and recovered quickly with electroconvulsive therapy (ECT) (Figure 1). In addition we performed a literature search on ECT and hypochondriasis, hypochondriacal/somatic delusion/psychosis and severe depression with hypochondriacal/somatic delusion/psychosis.

Case Report

A 72-year-old female without a somatic or psychiatric medical history was referred against her will to an outpatient psychiatric clinic by her gastroenterologist after a year of suffering nausea, pain in the epigastria and constipation. The patient was convinced she had a physical illness and no psychiatric illness. Her long lasting complaints had started 3 days after the start of oral nystatine prescribed for a Candida infection of the mouth, which she developed shortly after getting a complete set of dentures. Her appetite was diminished and she also complained of a bitter taste in her mouth. A thorough work up, including repeated physical examinations, gastroscopy, blood tests and an angiography of the abdominal arteries did not reveal a plausible cause for her complaints. Despite nightly drip-feeding the patient lost more than 20 kilograms during her frequent visits with the gastroenterologist.

At first psychiatric examination she was preoccupied with her somatic symptoms that were, according to her, due to nystatine use. She was diagnosed with hypochondriasis that was considered to lead to lack of appetite and disturbed sleep, which were present as well. Since she had severe trouble sleeping the antidepressant mirtazapine was started. Notably there were no complaints of depressed mood or anhedonia and there were no psychomotor symptoms; however she was very limited in her daily activities because of her physical complaints.

She remained preoccupied with her physical condition and was convinced that there was a not yet identified somatic cause for her symptoms. A year after the use of nystatine she feared that her gastric mucosa would dry out completely and that she had a rotten tube in her throat. These ideas were diagnosed as delusional. She was referred to the psychiatrists as a patient with somatization and a hypochondriac delusion. Evaluation of her depressive symptoms revealed a MADRS score of 25/60 without the patient reporting depressed mood or anhedonia. She complained of lack of appetite, disturbed sleep, diminished interest and inner turmoil. There was no psychomotor disturbance. Assuming a depression with psychotic features she was treated in vain with amitriptyline during 4 weeks with adequate blood levels and then refused further treatment. A second opinion confirmed a probable diagnosis of melancholia, a mood disorder with a hypochondriacal delusion. ECT was started after extensive counseling with the patient and her husband. Unilateral brief pulse ECT was administered twice weekly using a Thymatron IV, starting with a 70% dose setting (75 mCoulombs) resulting in 54-second motoric seizure and recording 82 seconds on the EEG. After the first treatment her physical symptoms were markedly improved, her appetite and sleep pattern recovered in the following two weeks. After 13 sessions of unilateral ECT she recovered completely and maintenance pharmacotherapy was started with nortriptyline. The following 2.5 years she was in complete remission and functioning well. Than she experienced a relapse and again she quickly recovered with ECT. Four years after the initial complaints of gastrointestinal discomfort she was diagnosed with colon carcinoma.

Discussion and Conclusions

The DSM IV-TR defines strict criteria to identify medically unexplained symptoms as psychiatric somatoform disorders. Somatiza-tion disorder requires a combination of gastro-intestinal and pseudo neurological symptoms, sexual and pain complaints. Whereas in hypochondria the fear of being ill is central and patients real-

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izes that their anxiety is exaggerated and that no major physical condition is present.

The syndrome of monosymptomatic hypochondriacal psychosis (MHP) is a form of DSM-IV delusional disorder, somatic subtype, characterized by the delusional belief that one is afflicted with a medical disorder of defect. Such patients often present to dermatologists with delusions of parasitosis. The literature describes case studies and 1 double-blind cross over study indicating the benefit from several typical neuroleptics, especially pimozide for this disorder,[5,6] atypical neuroleptics[7-11] or antidepressants.[12] Our patient is crossing the borders of the DSM IV criteria. Although she didn't fulfill the criteria for a delusional disorder because since she didn't believe she had a specific serious illness or defect and moreover her daily functioning was restricted, she was considered as a delusional disorder of the somatic subtype. She didn't meet criteria for any other somatoform disorder, as there were no other somatic complaints apart from nausea and weight loss. She was convinced that her complaints were side effects of nystatine, and a gastrointestinal problem could be found if more extensive diagnostic research was done.

According to DSM IV criteria a depression can only be diagnosed in presence of five or more symptoms including depressed mood or loss of interest or pleasure. Since 1980 classifying according to DSM III increased the reliability of psychiatric diagnoses and stimulated scientific research. In clinic practice however, symptoms, which not fit a certain psychiatric category, are easily missed. The diagnosis depression is not considered when depressed mood or loss of interest or pleasure isn't present. Recent research in four academic centers showed that the diagnosis depression with psychotic symptoms was missed in about 25% of the cases if the psychotic symptoms were more present than a disturbed mood.[13]

In the European psychiatric textbooks from the first part of the 20th century it was stressed that melancholy, especially in the middle age and elderly, had a protean clinical expression and could mimic several psychiatric conditions like hypochondria, delirium, catatonia and anxiety disorder, depending on the symptoms that are most prominent.[14] Severe depression with hypochondriacal delusion was described by Cotard in 1880 as *du delire hypochondriaque* and in 1957 by Schneider as *depressio sine depressione*. In the English literature the term *masked depression* was popular, however in most cases it appeared to concern the differential diagnostic considerations: somatoform or somatization disorder. There is limited research on depressive disorder with hypochondriacal delusions. As a subtype it would be more frequent in women[15] and accompanied with a high risk for suicide.[16] In a multivariate analysis of 187 patients with severe depression a subtype with hypochondriacal delusions could not be defined by specific characteristics, despite the number of variables that was analyzed.[17] There are two case reports describing a patient with hypochondriacal delusion improving after ECT.[18] There is a limited number of case reports on patients with hypochondriacal delusions treated with ECT.[19,20] We believe that hypochondriacal delusions as part of a severe depression might be undiagnosed following the strict criteria of the DSM IV-TR, moreover these patients aren't likely to consult a psychiatrist with their symptoms. Intensifying collaboration with our colleagues in internal medicine for example could make more cases of hypochondriacal delusion as part of a severe depression surface. Our patient was first diagnosed with hypochondria but over time she developed a hypochondrial delusion and was diagnosed with melancholia despite the absence of a prominent mood disturbance or loss of interest or pleasure. She was treated with electroconvulsive therapy and after one session her somatic complaints evaporated. Recognizing mood disorders without depressed mood or loss of interest or pleasure as prominent features will speed up adequate treatment and prevent unnecessary, costly test and delay.

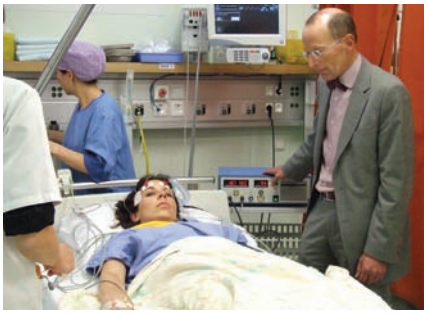

Figure 1. Electroconvulsive therapy.

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