CASE REPORT

Tiapride for monosymptomatic hypochondriacal psychosis (dysmorphic delusion subtype) in presenile patients

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Abstract

Monosymptomatic hypochondriacal psychosis (dysmorphic delusion subtype) can be seen in people of all ages. It is well known as being difficult to treat, especially in presenile and older patients. In younger patients, it is commonly treated with neuroleptics like pimozide but in presenile and older patients this form of treatment is limited because of the aversive side-effects of neuroleptics, such as extrapyramidal syndrome. The present study describes a successful course of treatment with tiapride in a presenile patient with monosymptomatic hypochondoriacal psychosis (dysmorphic delusion subtype) without any adverse side-effects when compared to other treatments and monodelusional disorders in elderly people. It is concluded that tiapride should be considered the treatment of choice for monodelusional disorders in presenile people.

INTRODUCTION

Monosymptomatic hypochondriacal psychosis (MHP) was defined by Munro and Chmara[1] as follows: MHP is characterized by a single hypochondriacal delusion system, distinct from the remainder of the personality. The delusion might be accompanied by illusional misperceptions or, at times, by poorly defined hallucinations. Munro reported that MHP makes an entity of one disease.[1–3] Reilly reported that this phenomenon has been called 'cenesthopathy' in Germany and Scandinavian countries.[4] Yoshimatu[5] and Takahashi and Yoshimatu[6] also noted that MHP has been used interchangeably with 'cenesthopathy' in Japan.

Additionally, by the latest classification of psychiatric disease, the *International Statistical Classification of Diseases and Related Health Problems, tenth revision* (ICD-10) MHP is classified as delusional disorder (F22.0): hypochondriac subtype.[7]

Various treatments have been tried for MHP, such as neuroleptics, antidepressants or electrical convulsion therapy, but MHP remains difficult to treat.[1–3,5,6] Munro,[1–3] Reilly[4] and Riding[8] have recommended pimozide for MHP.

Munro[1–3] beleive that there are two outburst peaks in adolescent people and presenile or elderly people. For adolescent patients with MHP, it is common to administer some kind of neuroleptics.[1–4] On the other hand, some psychiatrists have also prescribed antidepressants or other kinds of neuroleptics, like pimozide, for presenile or elderly patients with MHP.[5,6] But treatment for presenile or elderly patients is limited because of adverse side-effects, such as extrapyramidal syndrome.[1–4,9]

In the present report, the author describes a 60 year-old female patient with MHP who showed early obsessive symptoms such as an abnormal sensation in the oral cavity and dysmorphic delusions, successfully treated with tiapride. When the author[10,11] first reported the effects of tiapride for delusion of dermatozoiasis, one of the subtypes of MHP, it immediately become popular in Japan.[12] To the author's best knowledge, this is the first case report regarding the effects of treatment with tiapride on dysmorphic delusion of subtype of MHP.

The present report also discusses the treatment of monodelusional disorders in presenile patients.

CASE REPORT

The patient, a 60 year-old Japanese woman, did not have a history of psychiatric illness, nor any family

history of mental illness or alcoholism. Her premorbid character was punctual and scrupulous. Her chief complaints were abnormal pain, a rough and flabby feeling in her oral cavity, a feeling of her body being distorted and her arms becoming slender, swollen and spotted alternately.

The patient's illness progressed as follows. A few years ago, she could not go outside or sleep well because of her obsessive concerns with locking the door and gas leakages. She was prescribed fluvoxamine, zolpidem, or some other antidepressants under the diagnosis of obsessive-compulsive disorder, but her condition did not improve. Eight months ago, she had pain in her oral cavity because of a burning sensation in her mouth. The pain has continued since then. A few months later, she started complaining about an abnormal, rough and flabby feeling in her oral cavity. The patient believed her face in the mirror was distorted. Her body was also distorted; her arms becoming slender and swollen alternately. She could see her arms swelling and changing into a strange, indescribable color. The abnormal sensation of distortion was limited to her body; other things did not change their shape. Therefore, the patient was unable to sleep, filled with anxiety about her distorted body image and the abnormal sensation in her oral cavity.

She was introduced to our hospital because of the bizarre complaints and drug-induced Parkinsonism such as hand tremor caused by sulpiride 150 mg/day and zolpidem 5 mg/day. The author stopped sulpiride and administered fluvoxamine 150 mg and zolpidem 5 mg/day again. Her drug-induced Parkinsonism disappeared before she presented to our hospital.

At the first interview, she was alert and cited the above mentioned abnormal sensations of her body and oral cavity. Notwithstanding the summer heat, she wore gloves, long sleeves and long pants. Neurological studies showed no particular findings, especially extrapyramidal symptoms such hand tremor of Parkinsonism.

She was sent to be examined from an ophthalmological and otorhinolaryngological point of view by the author, but there were no particular findings. Thereupon, the author administered to her 75 mg/day of tiapride for the abnormal sensation of her body and oral cavity and 7.5 mg of zolpidem for insomnia.

Two weeks later, she began to not fear seeing her face in the mirror. Four weeks later, she could look at her face in the mirror without any fear, but still felt that her body was distorted, swollen and deflated. She said to the author, 'please look at my legs! You can see my legs are swelling now.' Six weeks later, she could see her face in the mirror without fear and no longer had concerns about the abnormal sensations in her face and body. She could wear a skirt and did not need to wear gloves anymore.

For approximately 6 months, she continued to take tiapride 75 mg/day and 7.5 mg of zolpidem before sleeping and no longer complained about abnormal sensations in her face and body.

Laboratory tests did not indicated any particular findings. Brain magnetic resonance imaging showed slight atrophy with multiple cerebral infarctions (Fig. 1). The electroencephalogram sometimes exhibited low voltage and slow waves. KOHS intelligence quotient examination suggested her IQ as 59, which was average for her age. Because average IQ by KOHS of patients more than 60 years is 58.4 ± 13.9. So she was not considered to have dementia.

DISCUSSION

The symptoms of this patient were diagnosed as symptoms typical MHP. Over some months, she had been complaining about an abnormal sensation in her oral cavity and the ugliness and misshapenness of her foot, but there were no physical findings or any other

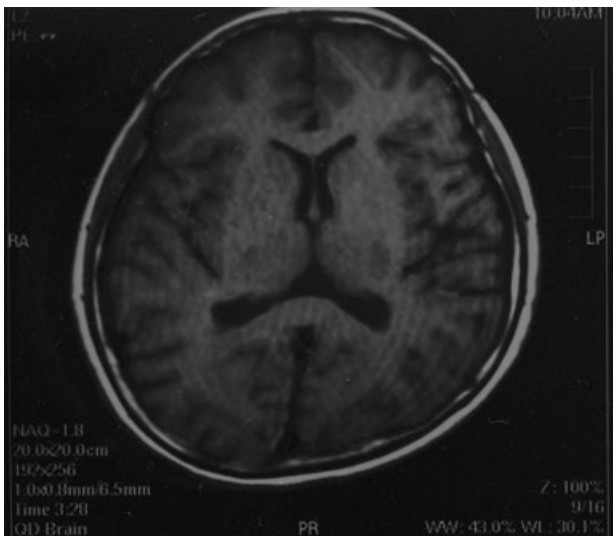

Figure 1 Brain magnetic resonance imaging showing slight atrophy with multiple cerebral infractions.

schizophrenic symptoms. Some antidepressant or fluvoxamine, one of the selective serotonin reuptake inhibitors, were administered for her symptoms, but they were not effective.

The case meets the latest diagnostic criteria, the ICD-10 criteria,[7] for a diagnosis of 'delusional disorder, hypochondriac type (code F22.0 hypochondriac type)'.

Rinding and Munro[8] emphasized that MHP should be an entity of one group. Subsequently, Munro[2] classified MHP into three subgroups:

- Delusion of body odour or halitosis
- Infestation delusion (insects, burrowing worms, or foreign bodies under the skin)
- Delusions of ugliness or misshapenness (dysmorphic delusion)

From these subgroup classifications, our patient falls under 'delusions of ugliness or misshapenness (dysmorphic delusion)'.

In Japan, psychiatrists use the technical term 'cenesthopathy' nearly interchangeably with MHP. Munro,[1–3] Yoshimatu,[5] and Takahasi and Yoshimatu[6] analyzed their patients with 'cenesthopathy' and discovered that there are two outburst peaks at adolescence and old age. Takahasi and Yoshimatu also suggested that cenesthopathy in the adolescent group is related to schizophrenia and in the elderly group to depression.[6]

Therapy

Monosymptomatic hypochondriacal psychosis has always been difficult to treat. Various treatments for MHP have been tried, such as neuroleptics, antidepressants, carbamazepine and electrical convulsion therapy.[1–6,8] Yoshimatu,[5] and Takahasi and Yoshimatu[6] suggested that neuroleptics such as pimozide and haloperidol are effective for the adolescent group in relation to schizophrenia and antidepressants for the elderly group in relation to depression. Rinding and Munro,[8] Munro,[1–3] and Reilly[4] recommended pimozide for MHP in all age groups.

Neuroleptics such as pimozide should be administered to presenile or elderly patients of this disorder with careful attention to aversive side-effects, such as extrapyramidal syndromes.[1–4,9] The patient was actually introduced to the author because of MHP and drug-induced Parkinsonism.

The patient was treated with many kinds of antidepressants for several months, but they were not effective. On the contrary, the symptoms had spread to other parts of the body. Within a few weeks of administration of tiapride, delusions of ugliness or misshapenness from the patient disappeared. Tiapride proved to be effective for the delusions. To the author's best knowledge, there have been no other reports of the effects of tiapride for delusions of ugliness or misshapenness (dysmorphic delusion).

The author reported that tiapride is effective for infestation delusion (insects, burrowing worms, or foreign bodies under the skin), one subtype of MHP.[10,11] Maeda *et al*. has confirmed its effectiveness for delusions of foreign bodies under the skin.[12] In Japan, tiapride for delusion of dermatozoiasis, which is the same as 'infestation delusion' has become a common treatment. Delusion of dermatozoiasis is one delusional disorder hypochondriac subtype in ICD-10.[7] MHP is classified as a monodelusional disorder.

The author has also examined the effectiveness of tiapride for pathological jealousy in elderly patients before.[13] Those reports of tiapride treatment for delusion of dermatozoiasis[10,11] and pathological jealousy[13] in elderly patients in addition to this report suggest that tiapride is an effective treatment for monodelusinal disorders in presenile and elderly patients without having any adverse side-effects.

Pharmacology

Tiapride has strong selectivity to only D2 dopamine receptor among other dopamine receptors.[14–17] It is a low potency, but a highly selective D2 dopamine receptor antagonist.[14–17] Tiapride has the advantage of having fewer adverse effects like extrapyramidal symptoms than other neuroleptics, even in aged patients. Tiapride is effective for presenile or elderly patients with abnormal behavior and emotional disturbance, suffering from cerebrovascular disease.

The patient also has brain organic factors of aging such as brain atrophy with multiple cerebral infarctions shown in the MRI. Electroencephalogram findings shown a slow wave and a slight decrease in IQ but which is considered normal range for her age. Therewith it is considered that the patient has slight organic change within normal limits for her age, she was not considered to have dementia.

CONCLUSION

The present report suggests that tiapride is considered the treatment of choice for MHP as well as for

all monodelusional disorders in presenile and elder patients.

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