

Somatic-type Delusional Disorder: A Case Report and Comments

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Somatic-type delusional disorder is characterized by the development of either a single delusion or a set of related delusions that are not bizarre and cannot be classified as organic, schizophrenic or affective. The nature of delusions may be very variable. Affected individuals typically complain of infestation, deformity, personal ugliness, exaggerated sizes of body parts, foul body odour or halitosis, and are thus more likely to consult a dermatologist than a psychiatrist (1, 2). Our aim in presenting this case report is to provide tips to dermatologists on how to take care of psychiatric patients who persistently consult them.

CASE REPORT

A 59-year-old woman was admitted to our dermatological ward because she was convinced that there were multiple purulent skin lesions on her back that had spread to her internal organs. She maintained that these symptoms first appeared 7 years previously, following her admission to hospital after a mosquito bite. The patient complained of numerous disorders during the previous years for which she had received treatment from various specialists (e.g., endocrinologists, gastroenterologists, gynaecologists, urologists) without seeing any improvement. A general physical examination and laboratory tests did not reveal any abnormalities. Dermatological examinations did not demonstrate any significant skin lesions besides a small scar on her back, which formed as a consequence of intensive self-scratching. While being attended to on the dermatological ward, she was also examined by psychiatrist MK-K, who reported that her "orientation to time, place and person, and also memory and cognition is intact". The patient was communicative, sometimes even garrulous, when describing the course of her disease. She reported many family problems (she was separated from her alcoholic husband but was still living in the same flat as him because of financial difficulties). She had proprioceptive hallucinations of a "double back" tingling sensation, caused, so she claimed, by viruses and infected fluid flowing through her whole body to her heart. The patient had no insight as to her real condition. She had retired because of her health problems and spent most of her spare time consulting numerous specialists. Her sleep was disturbed as a result of her sleeping in a sitting position in order "not to have her head flooded by internal pus". MK-K also noticed a high level of anxiety, although there were no mood disturbances and the affect was appropriate. She diagnosed the patient with somatic-type

delusional disorder (caused by the conversion of emotional tension into somatic symptoms and exacerbated by the menopause) and administered sulphuride at a dose of 200 mg/day. Because the patient was being treated on a dermatological ward, this treatment was complemented by the application of paraffin and vitamin ointments to her whole body in order to improve the general condition of her skin. After 7 days of hospitalization, the patient was discharged to be treated further in our outpatient clinic. Because of her resistance to being treated by a psychiatrist, she underwent regular dermatological and periodical psychiatric check-ups (every one and three months, respectively). Within the six months following her hospitalization, her mental state improved slightly and slight improvement manifested by attenuation of her body sensations. The patient also reported that she could sleep in a half-lying position in contrast to sitting before treatment was introduced.

DISCUSSION

In delusional disorder, delusions are usually persistent; their nature may be very variable, but not bizarre, which means that they originate from normal everyday situations (2).

Patients with somatic-type delusional disorder are typically well-groomed and do not present noticeable evidence of any impairment. Their speech, psychomotor activity and use of eye contact may be influenced by their emotional state and mood. Feelings and affect are consistent with the nature of the delusions. Patients do not have hallucinations other than tactile (including proprioceptive) or olfactory ones, which are related to the theme of the delusion. Their thoughts are disturbed, although thought processes are not usually impaired. While orientation, memory and cognition are intact, impulse control may be impaired and patients lack both judgement and insight. High levels of anxiety, hyperalertness and a hypersensitive and argumentative personality are also characteristic traits (2, 3). Although delusional disorder, patients may perform well occupationally and in areas distant from their delusions, they tend to be socially isolated as a result of shame, the fear of "transmitting" their imagined infection or their personality traits.

The precise aetiology of delusional disorder has not been fully elucidated. However, the roles of genetic, biological (hyperdopaminergic states) and psychological factors have been considered (1, 4). Although our

patient had no family history of delusional disorder, she had recently suffered a stressful life event (separation from her alcoholic husband). Delusions can develop as a response to stress and may serve to preserve a positive self-image. MK-K also suggested a possible connection between the onset of symptoms and menopause. Patients with delusional disorder absorb only selectively available information and make conclusions based on less information than healthy subjects and without considering alternative explanations (5). Difficulties in interpreting others' intentions and motivations seem also to be very common (6). Factors frequently associated with delusional disorder that affected our patient include being married, living in a city and having a low socioeconomic status. People who tend to be isolated, such as immigrants or those with impaired sight or hearing, appear to be more vulnerable to developing delusional disorder (7).

The treatment of delusional disorder involves both pharmacotherapy (antipsychotics or antidepressants) and psychotherapy (cognitive or insight-oriented therapy) (8, 9). There are difficulties in developing a therapeutic alliance and patients are likely to refuse medication because they can easily incorporate the administration of drugs into their delusional systems (10).

Because of our patient's reluctance to admit that her problems were caused by psychiatric issues, we decided to continue treating her in our dermatological outpatient clinic.

Delusional disorder patients lack both insight and judgement. As a result, their reaction to their diagnosis may be very variable – from calm denial to aggression. Moreover, in many societies psychiatric disorders are regarded as being embarrassing and highly stigmatizing. For this reason, patients prefer to consult a dermatologist, rather than a psychiatrist, if their condition involves the skin, and, if disappointed, are eager to change doctor (1, 5). Our patient was treated by numerous specialists, but none of them have managed to instigate psychiatric treatment because of the patient's refusal to comply. We therefore decided to admit her to our dermatological ward and to gradually reveal to her the details of her disorder. In particular, it proved to be very helpful to inform her in detail of the connection between the skin and the nervous system, including their common ectodermal

origin. We also discussed with our patient the possible indication of sulpiride because of the psychosomatic nature of her condition. This helped us to maintain a good therapeutic alliance with her.

Based on our experience, we would recommend all dermatologists develop a similar approach to treating patients presenting different psychiatric conditions, including depression or dysmorphophobia, and persistently consulting dermatologists. If we, dermatologists, do not help such patients, it may be that no one will. However, in order to enable dermatologists to achieve this, standardized specific training in basic psychiatry and psychopharmacology should be included in dermatological training. Moreover, psychiatric liaison consultations at dermatological wards should be made more easily available.

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