

DELUSION OF HAVING ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS): REPORT OF TWO CASES

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Abstract- This is a report of two cases of monosymptomatic hypochondriacal psychosis who were convinced of having acquired immunodeficiency syndrome.

They bitterly criticised the incompetence of their medical advisers, on of always showed virus-like particles of acquired immunodeficiency syndrome organisms beneath their lip mucosa or penile skin. The first case was advised to continue psycholytic compounds. Favorable results were obtained following a 5 months period. In the second case, amitryptiline and trifluoperazine were prescribed with comparatively good results. Acta Medica Iranica 37 (2): 119 - 122; 1999

Key words: AIDS, delusion, parasitophobia, psychosis, Iran

INTRODUCTION

The definition of delusion in diagnostic and statistical manual of the mental disorder (DSM-IV) is a false belief based on incorrect interference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. According to DSM-IV, the diagnosis of delusional disorder can be made when a person exhibits nonbizarre delusions of at least one month's duration that can not be attributed to other psychiatric disorder (1). Delusions of parasitosis are extremely rare (2,3). The review of medical literature in the last decade has not shown any reports of delusions of acquired immunodeficiency syndrome (AIDS). These patients had a conviction that their skin had been infested by parasites. Lyell has said, it is possible to spend a life time as a dermatologist and never see a patient with delusions of parasitosis (4). This must be differentiated from parasitophobia-the fear of becoming infested (2,5). The term monosymptomatic hypochondriacal psychosis may be applied

to patients with a single fixed hypochondriacal delusion which is apparently not secondary to another psychiatric disorder (5). Most patients with delusion of parasitosis fit into this category. Such patients are often intelligent and the professions are well represented including doctors and even psychiatrists, but they are often rather solitary and sometimes thought to be eccentric individuals (6). Indeed, Lyell has commented that it is hard to know where eccentricity ends and madness begins (2). Moreover some of these patients may have had a rather obsessional premorbid personality. Those seen by psychiatrists are more likely to be labelled schizophrenic or depressed or both. Delusions of parasitosis are also described in pellagra, vitamine B12 deficiency and severe renal disease and sometimes following a cerebrovascular accident (2, 3, 7, 8, 9). It is particularly important to exclude the possibility of a real infestation, and 6% of Lyell's series developed delusions of parasitosis following true infestation. Because of its high rate and rapid mortality and grave morbidity, phobia of AIDS is spreading in the entire world, but delusion is a false belief that arises without an appropriate external stimulus and that is maintained unshakably in the face of reason (10). Delusions are pathognomonic of psychosis(11), and differ from deep complicated hypochondriacal psychosis. Delusion affects both sexes equally below the age of 50 but after the age of 50 three times as many women are affected as men (2, 3). Both our cases were men and below 40 years of age who suffered of monosymptomatic hypochondriacal psychosis. We reviewed some studies on phobic or psychotic

stats compared to depression in patients with true HIV/AIDS. The findings that have been reported in the current literature are generally contrary to what would be expected from the significant biological and psychosocial stresses of individuals with HIV, and are inconsistent with those of other illnesses and CNS diseases. Clear conclusions regarding the prevalence of depression and its effect in patients with HIV/AIDS can not yet be made (12).

Case 1

A bank employee 29 year-old, widowed male was referred to the dermatology clinic. He said that he was suffering from some abnormal microorganisms creeping around his prepuce and glans penis, but whenever he decided to pick one up, it disappeared beneath the skin so he stated that he succeeded to catch some of these particles, but could not keep them in a matchbox to be shown to a doctor. He drew the shape of them in the form of an apostrophe and insisted that they were AIDS agents, and that he has found the way of suppressing his disorders by eating some wild vegetables and plant seeds. He recurrently looked at his penile shaft and showed the penile adnexal glands and mucosa of his lower lip. He believed in that there was a high density of these organisms. Recently, he had started believing that some of these organisms had emigrated to his pelvic cavity. In general examinations, he seemed well nourished, of medium stature and with no anatomical abnormalities in any organ. Sebaceous glands of lower lip (Fordyce's granules) and identical glands of penile ring (Tyson's glands) were normal in configuration and distribution. He had worked as a farmer for the last 5 years and in this period he had had bisexual activities with a person and with many animals. He felt better after sexual intercourse because he believed many particles extruded out of his penis. He was referred to a psychiatrist for consultation. At first he denied any psychiatric complications.

Ultimately he accepted to follow the orders and prescriptions of both the dermatologist and the psychiatrist, to stop the activity of these organisms. Laboratory examination showed no significant findings in relation to true disease in this case.

Case 2

A 35 year old married man was referred to the dermatology clinic for oral papules on the inner surface of the lower lip of 3 months duration. He was complaining of fluctuating flushing in his oral cavity. He felt that some mobile particles were moving beneath the mucosa of his pharynx, and that these particles had caused AIDS in him. He had been to a foreign country and had twice performed heterosexual intercourse with a prostitute. Depression was the only psychological symptom he had suffered from which 8 years ago, when he had been a bachelor. Physical examination of his upper and lower lip mucosa showed no abnormality with normal Fordyce's granules which he thought were AIDS agents. No abnormality was seen in configuration and color of pharyngeal mucosa. Paraclinical examination and evaluation of sexually transmitted diseases such as AIDS, gonorrhea, syphilis and other systemic viral diseases such as hepatitis were negative. Pimozide and amitriptyline were advised, with the impression of delusion of AIDS. After taking both amitriptyline and trifluoperazine for 40 days, he felt relatively comfortable and accepted that he had been mistaken in the beginning of his disease.

DISCUSSION

Monosymptomatic hypochondriacal psychosis and delusions that are related to the skin, such as scabies or pediculosis are not uncommon (13). During the past few years we have had the opportunity to observe two cases of these rare delusions. Both cases were male with no history of psychiatric disorders in the past or family

history of identical disorders. They are usually sporadic, as in our cases. AIDS has been recognised as a disease since 1981 but it was not until 1983 that human immunodeficiency virus type 1 (HIV-1) was recognised as the causative agent (14). It is particularly important to exclude the possibility of a real infestation, underlying organic diseases, and phobia of acquiring AIDS. Phobia of AIDS or "AIDS phobia", has been spreading throughout the world, (10, 16, 17). Depression has been reported in patients with HIV and AIDS, but delusions are pathognomonic of psychosis (11, 12), and differ from deep complicated hypochondriacal psychosis. Karlsen et al performed a study in Denmark on thirty-three patients with AIDS that were subjected to neuropsychological and immunological testing with semiannual examinations over a two year period (9). These two cases represent a new variation of delusions related to dermatologic disorders (3). The management of patients with delusional parasitosis is always difficult. The main problem with these patients is compliance which is often poor. Patients frequently refrain from follow up visits. When compliance is a problem, depot neuroleptics may be used (8,18). These patients see their problems in clear dermatological terms, whereas their medical advisers see them in strictly psychiatric terms. It is often impossible to bridge this gap in communication. Some patients with delusions of parasitosis are depressed, as our second case, and they are best treated with conventional tricyclic antidepressants, often with pimozide (8).

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