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Hypochondriasis and Huntington's disease

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Psychiatric symptoms are common in Huntington's disease and can occur years before the motor symptoms. We present an unusual case that presented as a hypochondriac disorder fourteen years before the appearance of choreic movements.

Key words:
Hypochondriasis. Obsessive-compulsive spectrum. Huntington's disease.

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Hipocondria y enfermedad de Huntington

Los síntomas psiquiátricos son frecuentes en la enfermedad de Huntington y pueden preceder en años a los síntomas motores. Presentamos un caso inusual que se inició como trastorno hipocondríaco 14 años antes de la aparición de los movimientos coreicos.

Palabras clave:
Hipocondria. Espectro obsesivo-compulsivo. Enfermedad de Huntington.

INTRODUCTION

Huntington's disease is a degenerative disease of the central nervous system characterized by choreic movements and progressive dementia that is transmitted by autosomal dominant inheritance.

Psychiatric symptoms are frequent and appear in any phase of the disease. They can appear years before the motor symptoms. In the Di Maio et al. study, 31 % of the 510 patients debuted with psychiatric symptoms.

Affective disorders predominated, although development of psychosis, obsessions and compulsions, behavior disorders and personality disorders, irritability and aggressiveness are also common.

Huntington's disease has been considered as a disease that fits into the obsessive-compulsive spectrum theorized by Hollander[2], based on the similarities existing between compulsions and repeated movements present in some neurological conditions.

Hypochondria also would occur in the obsessive-compulsive spectrum, due to the presence of thoughts focused on suffering diseases with appearance similar to obsessions[2].

Regarding the appearance of psychosis in Huntington's disease, a small percentage of patients develop schizophrenic like pictures, although approximately 30 % of the patients have isolated psychotic symptoms, generally associated to cognitive deterioration, dementia and affective disorders[3].

CLINICAL CASE

White, 66 year old, married male, admitted to the Psychiatry Department of the Hospital Universitario São João for a diagnostic study of his picture characterized by behavior disorder, aggressiveness, cognitive deterioration and incapacity to perform basic tasks.

The patient is retired, lives with his wife and 15 year old daughter. Athletic biotype and appearing older than he is, with general aspect and clothing that reflect personal abandonment. He has a curved posture with stereotypal movements of the lower and upper limbs and walking with a shuffle. He brings a bag full of different drugs, mainly vitamins and placebos, that he shows one by one, demanding a prescription.

He has been followed-up in psychiatric clinics since 14 years ago due to non-specific somatic complains («pressure in his head and face», «lack of strength in his legs», «neuritis», «decreased pressure in his brain»), easy irritability, frequent episodes of insomnia, sadness and overall lack of interest.

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In spite of being studied in our center, he frequently goes for other psychiatric care and primary health care simultaneously, with conversation permanently focused on the same complaints, not complying with the prescribed therapies and also personally deciding on abuse of vitamin supplements and placebos. Admitted to a psychiatric center, he demanded voluntary discharge within a few days, returning to the same behavior cycle, focused on hypochondriac concerns.

He uses all the medical resources at his reach, especially emergency services, where he goes continuously because he thinks he may have a serious disease. He undergoes many different examinations, but no organic causality is ever detected.

In recent months, there has been a frank deterioration of his physical condition, with weight loss of more than 20 kg, frequent episodes of psychomotor agitation with heteroaggressiveness, stereotypal movements of members, sialism, cognitive disorders and maladapted behaviors.

Born at full term without complications, he had a normal psychomotor development. Childhood and adolescence marked by environmental affective instability motivated by absence of father figure, who he did not know. Among his medical background, calcified pulmonary nodule stands outs. Without known relevant medical or psychiatric background in his family.

In the psychiatric examination on admission, he is alert and oriented in time, space and situation. He does not allow the interviewer to ask questions, dominating the interview with poor and circumstantiated conversation, focusing on non-specific somatic complaints, making therapeutic suggestions and suspicions of diseases. Urged to answer the questions asked him specifically, he insists on the previously described conversation, with a permanent concern and conviction of having a serious disease in which «neuritis», «cold sweat», «decreased pressure in the brain» and «lack of strength» are dominant aspects.

These symptoms clearly interfere in his overall functioning level. Refuted these aspects, there seems to be a total irrefutability against logic. His mood is mildly depressive. Without clear hallucinatory activity. Deficient attention and concentration capacity, with marked memory disorders, especially in recovery memory. Poor insight.

The following complementary tests were performed:

- Complete blood count, biochemistry with folic acid and vitamin B_{12}, VDRL, TPHA, HIV serology, hepatitis B and C serology, thyroid hormones: negative or normal values.
- EEG: low amplitude alpha base rhythm, with 8-9 Hz periods and moderate intermittent theta activity in frontotemporal regions, of right predominance.
- Brain CT scan and MRI: cortico-subcortical atrophy.

Sodium valproate 200 mg (1-1-1), risperidone 3 mg (1/2-0-1/2), fluoxetine 20 mg (1-0-0) and biperiden 2 mg (1-1-0) were prescribed.

During admission, he maintained a hypochondriac type picture of delusional dimension, with mild improvement of psychomotor agitation and heteroagressiveness, maintained marked cognitive deterioration. He was referred to the Neurology Service that confirmed choreoatetosic movements in upper and lower limbs. After genetic study, diagnosis of Huntington's disease was confirmed. In the subsequent months, his symptoms worsened and he is presents (one year later) in a frank dementia condition.

DISCUSSION

In this case, there were difficulties for the differential diagnosis for years, fundamentally between affective disorder, hypochondria and obsessive-compulsive disorder.

Although sadness, insomnia and overall lack of interest could be labeled as depressive symptoms, the clinical picture course, persistent ideation of suffering a disease and extreme intensity that the patient experienced this, ruled out primary affective disorder.

Following Barsky[4] we found more data in favor of the hypochondria diagnosis than obsessive-compulsive disorder: the body sensations are interpreted by the patient as symptoms of a serious disease, he does not resist it, he speaks about the disorder and considers his behavior appropriate.

Progressively, the doubts become irrefutable convictions, suggesting a somatic type delusional disorder. After, the marked cognitive deterioration and motor disorders oriented towards the diagnosis of Huntington's disease.

The onset of a picture of hypochondriac characteristics in a 52 year old subject without known psychiatric background suggests underlying organic disease. In spite of this, only the appearance of motor disorders fourteen years later allowed for the correct diagnosis and longitudinal understanding of the psychopathology.

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