DIFFERENTIAL DIAGNOSIS: DELUSIONAL DISORDER- SOMATIC TYPE VS ANOREXIA NERVOSA

Ana-Anca Talasman¹, Alexandra Dolfi²

Abstract: Delusional disorder is an illness characterized by at least 1 month of delusions but no other psychotic symptoms, according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). (1) Somatic delusions are among the most frequent types of delusion encountered for inpatients, alongside persecutory, referential, grandiose and jealousy type. The differential diagnosis with psychosis is the first to be done and it's suggested by the fact that delusions are persistent and non-bizarre. (2,3) Then all somatic and psychiatric conditions associated with development of delusions must be eliminated. We present the case of a 38-year-old female with delusional disorder-somatic type who was admitted with conflicting symptoms suggesting rather anorexia nervosa associated with somatic symptom disorder. But after a thorough interview and a few days of admission, the delusional symptoms came out and the diagnosis became clear.

Key Words: somatic delusions, anorexia, somatoform disorder

BACKGROUND: Delusions are fixed beliefs that do not change even when the person is confronted with evidence that clearly contradicts them. (2) These persistent delusions are not bizarre and they cannot be attributed to schizophrenia, affective disorders with psychotic symptoms, organic diseases or substance abuse. (3) Delusional disorder- somatic type involves a delirium focused on patient's own body, as an individual thinks that he or she is suffering from a medical condition and/or is experiencing physical sensations or bodily dysfunctions. (4) We report the case of a 38-year-old female, who was admitted in Alexandru Obregia psychiatry hospital on 21/03/2017 for anorexia and severe weight loss, multiple somatizations and somatic delusions. It was her first admission in a psychiatry hospital, the patient being treated in the outpatients' clinic for general anxiety disorder. She was admitted in our ward for one month, between 21/03/2017 and 21/04/2017. A second one, between 19/12/2017 and 29/12/2017, followed this admission.

HISTORY: The patient was firstly admitted in our ward on 21/03/2017 for severe weight loss, anorexia and somatic delusions, after hospitalization in Floreasca Emergency Hospital Bucharest between 24/02/2017 and 07/03/2017. Her admission in Floreasca Emergency Care Unit was due to extreme weight loss (15 kg in three months, the patient weighting 30 kg at the moment of admission) and severe anorexia. She was admitted in the ECU with altered general status, hemodynamically and respiratory stable, hypoalbuminemia and hypoproteinemia, hypocholesterolemia, low triglycerides and severe dehydration. She was administered IV fluids, minimal enteral nutrition, and parenteral nutrition with 1000kcal/day, glutamine, antioxidant therapy and pulmonary embolism prevention therapy. A psychiatrist who recommended admission in a psychiatry hospital and treatment with olanzapine 5mg/day and mirtazapine 45 mg/day examined her. She was discharged with the following diagnoses: anorexia nervosa with secondary severe cachexia, mixed personality disorder, insomnia, constipation, appetite disorder, and esophageal reflux. From her history we note that she has stopped eating for three months and her weight dropped from 45kg to 30kg during this time. She reports no allergies and no other hospital admissions besides the one in Floreasca ECU. She is being treated in outpatients' clinic for general anxiety disorder for 3 years with Paroxetine 20 mg/day but she stopped the treatment without medical permission three months ago. She is reporting multiple somatizations: abdominal cramps, lump in throat sensation, dysphagia

¹MD, PhD, Clinical Hospital of Psychiatry “Prof. Dr. Al. Obregia” Bucharest, No.10 Berceni Street, email: anaanca@yahoo.com
²Resident in Psychiatry, Clinical Hospital of Psychiatry “Prof. Dr. Al. Obregia”, Bucharest, email: dolfialexandra@gmail.com

Received November 1, 2017. Revised November 16, 2017, Accepted January 9, 2018

Rezumat: Conform Manualului de diagnostic și clasificare statistică a tulburărilor mentale, ediția 5 (DSM-5), tulburarea delirantă este caracterizată prin persistența cel puțin o lună a simptomelor delirante neasociație cu alte simptome psihotiche. (1) Delirul de tip somatic este printre cele mai frecvente tipuri intalnite la pacienții internați, alături de delirul de persecuție, referință, grandoare și geloie. Diagnosticul diferențial cu tulburările psihotice este primul luat în calcul și este sugerat de faptul că în tulburarea delirantă delirul este non-bizar. (2,3) Apoi trebuie să fie eliminate toate afețiunile somatice și psihiatrice asociate cu prezența ideilor delirante. Prezentăm cazul unei femei de 38 de ani cu tulburare delirantă- subtipul somatic, care a fost internată pentru simptome specifice mai degrabă anorexiei nervoase asociate cu o tulburare de tip somatoform. Însă simptomatologia delirantă a devenit evidentă după un interviu anunțant și câteva zile de internare, astfel clarificându-se diagnosticul.

Cuvinte cheie: delir somatic, anorexie, tulburare somatoformă
and constipation and states that she was diagnosed with irritable bowel syndrome 8 years ago. Her father died by suicide (hanging) 31 years ago. She hasn't been working long term in the past 2 years; she is living alone, is not married and doesn't have children. Until 2 years ago she worked in television as a news reporter but was laid off due to restructuration. After that she worked several short-term jobs (accountant, secretary) but couldn't find a long-term one.

PHYSICAL EXAMINATION: cachexia- 30kg weight with a severely low BMI (11.2), pale and cold skin, severe dehydration, muscular atrophy, low muscular tonus, kyphosis and scoliosis, high respiratory frequency (20/min), oxygen saturation of 90% and a blood pressure of 90/60 mmHg with tachycardia (regular pulse of 123 bpm).

PSYCHIATRIC EXAMINATION: It revealed a conscious and co operant patient, with a hygiene well kept, oriented in time and space, autosympathic and allopyschic oriented, visual and psychic contact easy to start and maintain, low amplitude mimetic and gesture, symmetric and anxious facies, spontaneous and voluntary hypoprosxia, no affirmative perception disturbances, no memory disturbance, slow rate of ideation and speech, spontaneous speech was present. Autolytic ideation was absent. She denied the depressive mood and ideation. Her speech was coherent and she presented somatic delusions related to her digestive symptoms: "I have a very big lump in my throat and it doesn't let me swallow my food. I can't swallow anything, just a drop of water or milk. I didn't eat all month in December because I was very constipated. I have irritable bowel syndrome and this makes me eat less. My abdomen swells very much and the lump in my throat is enormous it really doesn't let me eat at all. I've been so sick because of my colon and I dropped weight because of this. My appetite is low because of my colon problem, my stomach is getting too big and food cannot go inside anymore. Sometimes I want to eat and sometimes I don't. I don't really want to gain too much weight". She didn't present another type of delusions. Her speech was focused on her health state, abdominal symptoms and weight loss. Her mother states that she was a TV reporter and she was always concerned about her weight, being on a diet most of the time. The patient was very anxious, presented low appetite, mixed insomnias and partial insight "I don't think I'm very sick, my weight is just a bit low, I don't think I can die and all my belly symptoms are because of the irritable bowel disease".

PARACLINICAL EXAMINATION: first laboratory tests were ready on 22/03/2017 and showed hyperglycemia due to restructuration. After that she worked several short-term jobs (accountant, secretary) but couldn't find a long-term one.

and active charcoal 2 tablets/day. She was re-examined periodically during her admission. Her abdominal meteorism was ameliorated but on 11/04/2017 she developed a faecaloma and needed a microclism to ameliorate her state as her improvement in weight started to stagnate.

The neurology exam on 14/04/2017 was normal and the ORL examination on the same day showed discrete signs of esophageal reflux and mouth ulcers. She was prescribed omeprazole 20 mg/day.

03/04/2018: fecal occult blood test negative, potassium of 3.3 mmol/l, increased prothrombin time (13.9) and increased INR (1.24). Her cortisol was normal (17.69 microgram/dl) and she had normal blood proteins. Her labs at discharge on 21/04/2017 were in normal parameters and she was discharged with a BMI of 12.6.

COURSE AND TREATMENT: on the first day she received 15 mg of mirtazapine and 5 mg of olanzapine associated with intravenous 500 ml of 10% Glucose and 500 ml of 0.9% sodium chloride with 400 mg of vitamin B1 and 100 mg of vitamin B6 (both in injection form, administered in perfusion).

On 22/03 patient's somatic delusion was persistent "I can't swallow anymore, I don't have the deglutition reflex. I feel how my colon is swollen and the deglutition reflex is linked to the colon. I can't eat but I can lick stuff that's good like coke and chocolate. I can't bite pieces of food". She reported severe constipation and her abdomen was bloated and painful on palpation. Arginine 250 ml IV/ day, active charcoal 3 capsules/day, lactulose syrup 20 ml/day and Drotaverine hydrochloride 40 mg IV twice a day were added to her treatment after the internal medicine consult. The next three days her evolution started to improve. She started to eat yogurt and waffles but was still anxious "I feel a bit better, I can bite a bit of food. My deglutition reflex has come back partially. I could eat soup". Her dose of olanzapine was increased to 10 mg while the rest of her treatment remained unchanged.

On 28/03 she reports that she can't swallow the 10 mg Olanzapine because "It's way too big and my deglutition reflex is low" so she is administered the velotab and she accepts the treatment. On 29/03 she maintains her delusion but in lower intensity. She starts to refuse the IV treatment because "I developed a low tolerance for pain" but she accepts it after she is administered a local anesthetic. On 03/04 she becomes anxious about her sleep "what if this treatment is way too strong for me and I sleep so deep that if an earthquake comes I won't get up and die?" She is anxious about her health and about the fact that "I'm not sure I want to put on a lot of weight, maybe 35 kg would be enough" but she is not refusing food and is accepting the treatment. She presents high emotional lability, her tolerance to frustration is low and she cries easily. Her olanzapine is increased at 15 mg/day with additional increase in mirtazapine to 30 mg/day on 05/04. On 10/04 her somatic delusions have almost disappeared. She goes down with the other patients to eat (by then her food was brought in the ward) and she eats small portions of all the courses served. She starts to swallow the pills so the IV treatment is replaced with oral tablets of vitamin B1 and B6. She also administered omeprazole, lactulose and activated charcoal as the constipation persists. On 11/04 she reports abdominal pains, being diagnosed with a
fetaloma so a microclism was necessary. Her delusions returned as her somatic state worsened. So she stopped eating and states that "my deglutition reflux has disappeared" On 13/04 the constipation was resolved so her somatic delusion decreased in intensity and she started to eat like before.

The patient was discharged on 21/04/2018. At the moment of discharge her insight was still partial "I know that it's stupid that my colon is related to the deglutition but I still strongly feel that if my colon in bad my deglutition reflux becomes worse" but she had appetite and she was eating three meals a day in small portions (around 1400 kcalories). Her BMI on discharge was 12.6 (34 kg) and her blood parameters were normal. Her constipation was treated with lactulose and capsules of charcoal and she was prescribed 20 ml lactulose/day and 3 capsules of active charcoal in case constipation recidivates. She was also prescribed omeprazole 20 mg/day for her esophageal reflux Her psychiatric treatment on discharge: olanzapine 20 mg/day and mirtazapine 30 mg/day.

LATER EVOLUTION: A second 10 days admission followed later that year, between 19/12/2017 and 29/12/2017. She was brought by her mother for emotional lability, interpretativity, fragmentary somatic delusions, anorexia and generalized anxiety. Those symptoms were associated with somatic accuses like abdominal cramps, constipation and meteorization of the abdomen. The patient stopped the treatment without medical permissions 2 months before the current admission. Her BMI was lower than after the last discharge (11.9), the patient weighing 32kg. Her physical examination showed integumentary and mucosal pallor with tachycardia and low blood pressure (127 bpm and 80/60 mmHg), abdominal meteorism and painful abdomen on palpation without peritoneal irritation signs. She was examined again by the internal medicine department being prescribed microclism with lactulose and active charcoal in the same doses as before.

Abnormal blood parameters: creatinin 1.7 mg/dl, total bilirubin 1.7 mg/dl with a direct bilirubin of 0.74 mg/dl, uric acid 8.89 mg/dl, low HDL cholesterol 32.7 mg/dl, high amylase 137.25 U/L, thrombocytopenia (93 000), low potassium 2.7 mmol/l with normal sodium, hypocalcemia (total calcium 7 mg/dl with ionic calcium of 3.87 mg/dl) and low total blood proteins 4.5 g/dl. Her hematological parameters and the other biochemical lab tests were normal. A nephrologist examined her on 20/12 and recommended 3 L of IV fluids and glucose 10% with 12 kcalories. Her BMI on discharge was 12.6 (34 kg) and her blood parameters with her BMI being 12.6 (similar to the last discharge). The indicated treatment was aripiprazole 20 mg/day, sodium valproate 600 mg/day divided in 300 mg doses for morning and evening, vitamin B1 and B6 complex 3 capsules/day, lactulose syrup 20 ml/day with active charcoal 2 capsules/day in case of constipation and potassium supplement 3 capsules/day.

DISCUSSION: The particularity of this case is in the differential diagnosis. The initial symptoms and hospitalization in the ECU due to extreme weight loss with cachexia were strongly suggesting anorexia nervosa while the associated abdominal symptoms could have been due to a somatic symptom disorder. The admission in Floreasca Emergency Hospital eliminated all the physical causes of weight loss and all somatic diseases that could determine delusions (substance intoxication, metabolic disorders, vitamin deficiency, endocrinopathies, encephalitis, other infectious causes and neurological diseases). (5,6) She was discharged from the ECU with anorexia nervosa but at her admission in Alexandru Obreja hospital, her delusional symptoms were evident but she also had ideas that could have been referred to anorexia (been on diets most of the time in the past years, preoccupied with her weight) but these ideas didn't have pathological intensity so we eliminated anorexia as a secondary diagnosis. Her thoughts were dominated by the somatic delusion of "there is something wrong with my colon and this completely stops my deglutition reflux", fact which directed the diagnosis to delusional disorder-somatic type. We also eliminated body dysmorphic disorder from the possible list of diagnoses as she didn't have any excessive preoccupation related to her body, besides the delusion focused on her gastric symptoms.

CONCLUSION: The diagnosis of delusional disorder-somatic type can become a challenge when the patient presents symptoms similar to anorexia nervosa such as extreme weight loss and refusal to eat. The case presented above was an example that confirms this challenge and states the importance of differential diagnosis in both delusional disorder and anorexia nervosa.

REFERENCES: