

Hypochondriasis (DSM-IV-TR #300.7)

In hypochondriasis patients come to believe, or at least to very strongly suspect, that they are sick with a serious, perhaps life-threatening disease. Minor symptoms or anomalies support and augment their concern. A muscle ache or perhaps an accidental bruise indicates the dreaded diagnosis. Their concerns persist despite the reassurances of their physicians. The preoccupation with illness may become all-consuming; some patients become invalids, bed-bound not by their symptoms, but by their fear of having a disabling illness.

Hypochondriasis has a lifetime prevalence somewhere between 1 and 5%, and appears to be equally common in males and females.

ONSET

Hypochondriasis may begin anywhere from teenage to older years. The peak age of onset is in the twenties and thirties.

As yet, no apparent premorbid or prodromal changes have been identified. In some cases, however, precipitating factors appear to play a role. Witnessing someone else suffer or die of a disease seems at times to trigger hypochondriasis. In some cases a serious illness in the patient's own life may precede the onset of the hypochondriasis. The postmyocardial infarction patient who becomes a "cardiac cripple" is a familiar example.

CLINICAL FEATURES

Patients with hypochondriasis come to the physician already certain that they have a serious disease. A cough has appeared; it is a sure sign of pneumonia. The pulse quickens, and the patient is sure that the heart will fail; a discomfort in the chest, and the patient is convinced that a heart attack is occurring; some nausea, and the patient becomes convinced that an ulcer has eaten through the stomach; the bowels are sluggish, and the patient fears cancer of the colon. Diffuse aches and pains are to the patient a sure sign of AIDS.

Often patients present their complaints in minute detail. They may bring lists or calendars with them. If they have been to other physicians, as is often the case, they may complain about the other physicians' refusals to take them seriously and their failure to order more tests. Often the examining physician feels uncomfortable, as if under attack. An appropriate interview and examination are generally unrevealing, or if findings diagnostic of a certain disease are evident, the patients' complaints are all out of proportion to what one generally sees with that disease. Indeed the patients themselves are often dissatisfied with the diagnosis. For example, patients convinced that they have serious heart disease may receive the diagnosis of costochondritis with skepticism, if not thinly veiled hostility. They may demand some tests, convinced that something has been missed. They have read about cardiac catheterization and are willing to undergo it.

"Doctor shopping" is predictably common in patients with hypochondriasis. They may bring photostatic copies of all their records with them. Their symptoms change with time, and this may be presented as grounds for a new round of tests. Occasionally the careful, meticulous physician may be able to get the patient to admit that perhaps in fact little is wrong and that further testing is not appropriate. However, such a fragile alliance between physician and patient rarely lasts. Indeed within minutes after leaving the physician's office, doubts may enter the patient's mind. The physician-patient relationship generally deteriorates; the patient becomes resentful, and the physician becomes at the least irritated with the demanding patient who will not accept reassurance.

The symptoms of hypochondriasis, though perhaps most clearly highlighted in the physician's office, are often present in all facets of the patient's life. The preoccupation with minor symptoms, the persistent conviction that one suffers a serious (though perhaps undiagnosed) disease, and the ineffectiveness of medical reassurance may be evident at the dinner table, the office, or the club. Similar to "doctor shopping," patients with hypochondriasis tend to "people shop" until they find someone who is willing to listen to their tale of woe with a sympathetic ear. Some degree of anxiety and depression are common in these sufferers; at times they may appear irritable, beaten down, a picture of suffering.

COURSE

Once established, hypochondriasis tends to be a chronic lifelong illness, with symptoms waxing and waning over the months or years. Patients may have interludes of partial remission during which, though still worried, they may make few demands on the physician. Rarely, true remissions may occur.

COMPLICATIONS

Hypochondriasis may indeed be disabling. Convinced of their illness, patients may quit work or refuse to travel. Their unreasonable demands may drive away friends and family. Unwary physicians may consent to provide various diagnostic procedures with the subsequent risk of iatrogenic illness. Some patients eventually opt for admission to a nursing home.

ETIOLOGY

Although personal or vicarious experience of illness is suspected to be related to hypochondriasis, as yet nothing certain is known about the etiology of this disorder, except that it is not familial. In retrospect, one may find that as children these patients were quite ill, perhaps with severe recurrent bronchitis or asthma. Alternatively one may find that these children were subject to maternal overprotectiveness and oversolicitousness regarding minor complaints such as stomachaches and the like.

The same experiences may be found in adulthood. Perhaps the best known is the case of the "cardiac cripple," wherein, after recovering from a myocardial infarction and being given clearance by the cardiologist to resume activities, the patient, un-reassured and consumed with the fear of having another heart attack, remains an invalid.

DIFFERENTIAL DIAGNOSIS

In Briquet's syndrome, patients present their symptoms in a colorful, dramatic, and often maddeningly vague fashion, in contrast to the often carefully detailed description given by patients with hypochondriasis. Furthermore, in Briquet's syndrome the emphasis is not so much on what the symptoms imply, namely having a serious disease, as it is on the seriousness of the symptoms themselves.

In conversion disorder the presenting complaint generally relates to a loss of ability or function, such as blindness, anesthesia, or focal weakness, rather than to misinterpreting a minor symptom, such as a bruise, as indicating a serious illness. Furthermore, some patients with conversion disorder display "la belle indifference" to their symptoms, in striking contrast to the anxious concern displayed by the patient with hypochondriasis.

Body dysmorphic disorder and hypochondriasis may be distinguished with reference to the underlying motivation of the patient's concerns. In hypochondriasis a blemish is of no concern per se; rather what is of concern is what the blemish means, namely that it is a sign of some serious underlying disease. In contrast, in body dysmorphic disorder the disfiguring effect of the blemish itself is the source of the concern.

In both malingering and factitious illness a purpose may be discerned behind the patient's complaints. In malingering, the purpose, such as financial gain or avoidance of responsibility, may be obvious. In factitious illness, the patient's intent, which is none other than to be under medical care or hospitalized, may be harder to discern. One clue may be the patient's attitude toward repeated, and ever more dangerous, tests: though both hypochondriacal and factitious patients accept these, and may even request them, the hypochondriacal patient approaches them with anxiety and trepidation, whereas the factitious patient typically shows little concern or apprehension.

In depression, patients may sink into a conviction that they are ill, and minor changes in function may solidify that belief. Simple constipation may convince the patient that the bowels are locked with cancer; elderly depressed patients are particularly likely to express such "hypochondriacal" concerns, and in fact may deny feeling depressed at all. Indeed such hypochondriacal concerns are what often bring the patient first to medical attention, as they seek consultation with their primary care physician. In such cases a vigilant attention on the part of the primary care physician to other symptoms of depression may enable the correct diagnosis to be made and spare the patient a fruitless workup for other causes.

Other differential points between hypochondriasis and depression are the presence of delusions and an episodic course. In some cases of depression the hypochondriacal concerns may become delusional and resistant to all

reassurance, in contrast to hypochondriasis, where reassurance is always effective, at least for a time. The course of the patient's concerns is also important; as noted earlier, true and full remissions are rare in hypochondriasis: thus, if there are long intervals wherein the patient is free of hypochondriacal concerns, the diagnosis of depression, which is more commonly episodic, is much more likely.

In histrionic personality disorder, the patient's presentation may be laced with hypochondriacal complaints; however, these constitute only a minor theme in the overall drama.

In schizophrenia and at times in schizotypal personality disorder, patients may be convinced that they have some other disease. These convictions, however, in contrast with hypochondriasis, are often either delusional or bizarre. The patient with hypochondriasis may complain of abdominal pain; the patient with schizophrenia may complain of "movements, like snakes" in the belly.

Transient hypochondriacal concerns are relatively common, are seen as normal variants, and should not prompt a diagnosis of hypochondriasis. The various "doctor's diseases" suffered by medical students are a good example.

Finally, one must be alert to the possibility that the minor symptoms do in fact indicate a serious disease. The patient who complains of chest pain may not be having a myocardial infarction; however, he may be experiencing pleurisy secondary to systemic lupus erythematosus: each complaint must be evaluated on its own merits.

TREATMENT

If patients can be convinced to attend, group psychotherapy appears to reduce "doctor shopping" and invalidism, and recent data also suggest an effectiveness for individual cognitive behavioral therapy. In all cases, one must inform the patient's other physicians of the diagnosis.

Most patients with hypochondriasis, unfortunately, do not accept a referral for psychotherapy. In these cases, the primary care physician should see the patient for an appropriate examination on a regularly scheduled basis. If patients are not seen on a regularly scheduled basis, but told to come back only if they "need to," the hypochondriasis often worsens. Overall, medical management should be very conservative.

Benzodiazepines are often prescribed, but their usefulness here is doubtful. A preliminary, open investigation suggested that fluoxetine, in doses of 60 to 80 mg, may reduce hypochondriacal concerns.

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