

Case Report

Uncommon delusion disorder of changed facial expression and dilemma of somatic or sexual subtype

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Abstract: A dermatologist may encounter a patient with somatic delusional disorder. Here, we report a case of an uncommon delusional disorder who had delusion of changed facial expression, who initially presented to a dermatologist and had a diagnostic dilemma of somatic or sexual subtype. The collaboration care approach was adopted in management resulting in a good outcome.

Keywords: Somatic delusion, Sexual delusion, Delusional disorder, Delusion of facial expression.

INTRODUCTION

Delusional disorder is the presence of a delusion or a set of related delusions, other than those listed in the diagnostic criteria of schizophrenia (Other than completely impossible or culturally inappropriate) [1]. Absence of insight and persisting conviction differentiate it from obsessive thoughts. The lifetime prevalence is $\leq 1\%$. Among delusional disorder, persecutory type is most common, followed by jealous and somatic type [3]. Here, we report a case of an uncommon delusional disorder that had a diagnostic dilemma of somatic or sexual type.

CASE REPORT

The 50 year old married Hindu male from urban background was referred from the department of dermatology for psychiatric evaluation. He reported that for three years his facial expression had changed, like a facial expression of a man engaged in sexual intercourse with a woman. His interaction with others reduced as he felt that everyone would stare at his face and talk about it. He also felt that women get anger on seeing his face, though they never confronted him. If he goes out of his house, he would cover his face to avoid embarrassment which distresses him. His conviction persisted despite contradiction from friends and many others. He finally consulted a dermatologist in hope of a surgical intervention in order to alter the facial expression. He also reported that for the last six months he was sad, felt worthless, lost interest in pleasurable activity, easily fatigued and was preoccupied with this problem. Since he is the only earning member, he continued working as a baker despite all difficulties.

There was no evidence of the dermatological or neurological disorder. There was no history of witnessing person engaged in sexual activity, watching pornographic movies, changes in sexual behaviour or sexual dysfunction, changes of sexual preference or orientation, other psychiatric disorders such as schizophrenia, personality disorder, obsessive compulsive disorder, body dysmorphic disorder or substance abuse. There was no family history of mental illness. Physical examination, including dermatological examination did not reveal any abnormality. Mental status examination corroborated the history findings. No suicidal ideation could be elicited. As per the International Classification of Mental and Behavioural Disorders, 10th version, a diagnosis of persistent delusional disorder with mild depressive episode was made. After developing rapport, in collaboration with dermatologist, stigma related psychiatric consultation was addressed. Due to his preference, he was prescribed tablet Escitalopram 10 mg per day and tablet Amisulpride 200 mg per day. He improved markedly after four weeks without any significant adverse effect. He stopped covering face while going out of his house, started interacting with others and depressive symptoms were improved. Same medications were continued without relapse for 6 months. Supportive therapy was provided to reduce anxiety and reassure the patient.

DISCUSSION

This case report is unique in many ways. Firstly, this case presented with two prominent delusions contrary to the commonly reported of single delusion in delusional disorder. This created a dilemma in the diagnosis; whether it is a somatic delusional disorder or sexual delusional disorder or a combination

of both. Another reason for such confusion was that patient's face was the locus of delusional theme and both symptoms emerged simultaneously. However, the sexual theme was the focus of attention and more distressing. In this case, the delusion was changed facial expression that is contrary to common presentation of disfigurement, infestation, dysmorphic, smell, teeth and face or venereal disease [4]. Depending upon the system involved, patient consults specialist. Usually patients with somatic delusional disorder consult plastic surgeon or dermatologist. In this case, the patient first consulted a dermatologist who played an important role in the identification and management. The collaboration care approach was adopted that helped to overcome the stigma associated with psychiatric consultation and compliance. Secondly, unlike sexual delusion that involves sexual organ or an act of sexual intercourse, in this case face was involved with sexual theme [5].

Treatment response to a low dose of Amisulpride (200 mg/day) and Escitalopram further augmented the diagnostic confusion. Usually a delusional disorder responds to a high potency antipsychotics in higher dose [6]. Amisulpride has a preferential blockade of presynaptic D2/D3 receptors in lower doses, and have been reported to improve delusional disorder [7, 8]. As observed in this patient, depression is most common comorbidity that responds well to an antidepressant [6].

Delusional disorder usually occurs in 3rd or 4th decades of life, common in unmarried women, in lower socioeconomic status. Neuroimaging studies reveal greater lateral ventricle volume, reduced blood flow in left parietal and temporal regions. Genetic studies reveal involvement of Dopamine D4 receptor (hD4R) 12 bp repeat in axon 1, DRD2 gene Ser311Cys in susceptibility [9]. Neuropsychological studies reveal increased perceptive abilities and attention disorders, an excessive need for closure and tendency of jumping to conclusions, impairment of attention, memory and psychomotor skill tasks [10].

CONCLUSION

This case report provides a rare insight into one of the most uncommon presentation of

delusional disorder and better prismatic view of how varied a somatic disorder can present at out patient basis. Hence should always be kept as a diagnostic possibility.

REFERENCES

1. World Health Organization. The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research. Geneva: World Health Organization; 1993.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders Text Revision. Washington, DC: American Psychiatric Association; 2000.
3. Hsiao MC, Liu CY, Yang YY, Yeh EK; Delusional disorder: retrospective analysis of 86 Chinese outpatients. *Psychiatry Clin Neurosci.* 1999; 53 (6): 673-6.
4. Mak KY; The interesting phenomena of delusional disorders. *Hong Kong Practitioner*, 2001; 23 (6): 251-257.
5. Melliou H, Daskalopoulou E, Evdokimides I, Gourounti K, Christopoulos P, Kreatsas G, *et al.*; Sexual delusion in a case of vaginal aplasia after surgical operation for neovagina. *Clin Exp Obstet Gynecol* 2012; 39: 239-41.
6. Manschreck TC, Khan NL; Recent Advances in the Treatment of Delusional Disorder. *Can J Psychiatry* 2006; 51: 114-119.
7. Mak YK, Lai STK; Use of Amisulpride in a Psychiatric Outpatient Clinic in Hong Kong. *Hong Kong J Psychiatry*, 2004; 14 (2): 2-7.
8. Bhatia MS, Chaudhary G; Delusional Parasitosis-case Report. *Delhi Psychiatry J* 2007; 10: (2): 147.
9. Grover S, Gupta N, Mattoo SK; Delusional Disorders: An Overview. *German J Psychiatry* 2006; 9:62-73.
10. Lepsavić I, Lepsavić L, Jašović-Gašić M; Neuropsychological profile of delusional disorder. *Psychiatria Danubina*, 2009; 21 (2): 166-173.
11. Davis PJ, Gibson MG; Recognition of posed and genuine facial expressions of emotion in paranoid and nonparanoid schizophrenia. *J Abnorm Psychol* 2000; 109: 445-50.