

ILLNESS ANXIETY DISORDER RELATED TO FILARIASIS: A CASE REPORT

By

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Abstract

Lymphatic filariasis is a parasitic disease which is associated with anxiety and depression and may also result in social isolation. We present here a case of illness anxiety disorder where the patient developed a morbid fear that he will develop filariasis.

Key Words: Filariasis, Illness Anxiety, Hypochondriasis.

Introduction

Lymphatic filariasis is a common parasitic disease affecting about 120 million people in around 80 countries throughout the tropics and subtropics (Palumbo, 2008). Its manifestations include the enlargement of the entire leg or arm, the genitals, vulva and the breasts (WHO, 2000). New models are needed to stimulate deeper examination of the interacting influences of initial tissue damage, acute pain, psychosocial contingencies, and central stress pathways during chronic symptom development after motor vehicle collision. The deeper understanding could contribute to improve treatment approaches to reduce the immense personal and societal burdens of the common trauma-related disorders (McLean *et al*, 2005). Decreased mobility, difficulty in self-care, and loss of employment along with pain and discomfort interfering with day to day activities are common factors that impair quality of life in this illness (WHO, 1998). The long term complications of filariasis from a psychosocial stand point include financial problems, dependency on others for self-care, singlehood and anxiety and depression arising from the intertwining of various factors (Suma *et al*, 2003). Patients with large elephantoid legs become victims of ridicule and stigma due to the massive skin folds and dreadful odour they emit. This may also result in social isolation and further accentua-

tion of psychological morbidity (Krishna Kumari *et al*, 2005).

This paper presents a case of illness anxiety disorder where the patient developed a morbid fear that he will develop filariasis and discuss the implications of such clinical cases.

Case report

A 23 year old unmarried engineer was brought by his parents to the psychiatry outpatient department with chief complaints of a 'worry' that he would contract 'Filariasis'. He was apparently alright till a year prior to presentation when he developed a pain in his lower limbs that lasted for a few days. There was no history suggestive of any trauma or injury to the lower limbs. He went to his family physician who advised him to get an X-ray of his both lower limbs (Knee and Ankle joints) done. He had come to our hospital to collect the X-ray reports and was waiting in the queue for his turn to come. Besides him, was a man who had an open wound in his lower limbs and was seated on bench next to the queue? The patient's X-ray suggested no abnormality and his leg pain subsided in few days. He was asymptomatic for next 6 months.

After 6 months, the patient developed fever, body-ache and limb pain particularly of the lower limbs. He suddenly remembered the man he had seen while waiting in the queue to collect his X-Rays and started say-

ing that he is suffering from filariasis as he had read about filariasis a few days back in a newspaper. He had read that a patient having filariasis would have swelling in the lower limbs and various other complications like ulcers in the lower limbs. He claimed that the parasites causing filariasis had entered his body by some insect bite that occurred a few days prior. He started worrying that he would also develop swelling and wounds in his lower limbs. He began to imagine that his limb would not be able to function properly and that he would become immobile. He will become inefficient at work and will be terminated from his job. He began expressing depressed mood, exhibited depressive features and began to feel that life was not worth living. He began asking his parents to kill him or give him poison. He would occasional get very anxious with these thoughts and would develop palpitations, breathlessness, tremors of the body and increased sweating (like a panic attack) with the episode lasting 5-10 minutes and subsiding on its own. He also complained of sleep disturbances in form of difficulty in going to sleep, getting sleep after 2 hours of lying down in bed and intermittent awakenings multiple times in the night. His appetite had decreased as well.

His parents tried to convince him that it was not possible to contract filariasis just by seeing the wound of a person, but this was to no avail. He went to his family physician to get various blood tests done which were within normal limits. He also demanded getting an MRI or a PET scan done to look for filarial parasites in his body. The physician tried in vain to explain to him that there was no such need. On the advice of their family doctor, a psychiatric referral was sought. The patient was psycho-educated with regard to the pathogenesis of filariasis, how it is caused, the life cycle of *Wuchereria bancrofti* and the course of the illness but this was not sufficient to reduce his worry or depression. He restarted working and was regular at his work as his financial condition

was poor and he could not afford to be without a job. There were no complaints suggestive of any other psychiatric illness.

In his past psychiatric history he was diagnosed as a case of obsessive compulsive disorder (OCD) in 2009 for which he had sought treatment from our hospital but he had misplaced all previous records. His parents claimed that he used to have repeated checking behaviour and if not allowed to do so would get irritated. He had improved in the past with medications over a 2 year period and was off medications since 3 years prior to the present episode. He currently did not have any symptoms suggestive of OCD. The patient had no significant medical or surgical illness and there was no family history suggestive of psychiatric illness.

On mental status examination he was cooperative and appropriately groomed. He was preoccupied with the thoughts of being inflicted with filariasis and this belief was firmly held though not firm enough to be labelled a delusion. All efforts to challenge his thinking resulted in momentary agreement with our thoughts but later he would still doubt that all we are saying is to just reduce his anxiety. He also had ideas of the hopelessness and worthlessness secondary to this fear. His insight was 3 on scale of 1 to 6 as he attributed his complaints to medical cause. The patient was diagnosed as having Illness Anxiety Disorder - Care Seeking type as per Diagnostic and Statistical Manual 5 (Slep *et al*, 2015).

For treatment, the patient was given the Blonanserin 8mg in divided doses as he wanted a non-sedating medication. Also, the patient started on Escitalopram 10mg per day and Clonazepam 0.25mg was given on an as and when basis. After 15 days, on follow up his complaints had reduced by 20% and the dosage of Blonanserin was stepped up to 16mg in divided doses. He was following up regularly and showed 80-90% improvement. Lastly, he was regular at work and stopped worrying about the fact that he would contract filariasis.

Discussion

Lymphatic filariasis (LF) is caused by filarial worms that live in the lymphatic system and commonly lead to lymphoedema, elephantiasis, and hydrocele. LF is recognized as endemic in 73 countries and territories; an estimated 1.39 billion (thousand million) people live in areas where filariasis has been endemic and is now targeted for treatment. Global momentum to eliminate LF has developed over the past 15 years as a result not only of research demonstrating the value of single-dose treatment strategies and point-of-care diagnostic tools, but also of both the generous donations of medicines from the following committed pharmaceutical companies (Ichimori *et al*, 2014). Illness anxiety disorder is a new diagnosis introduced in DSM-5 and replaces the rubric of hypochondriasis framed in the DSM-IVTR (Trull *et al*, 2012). Patients with the disorder visit various doctors with the aim of seeking solace that they have a particular disorder and try to coerce doctors into doing various tests and investigation in order to establish the diagnosis they desire (van den Heuvel *et al*, 2014). The patient however did not indulge in doctor shopping and prompt psychiatry referral by his vigilant family physician ensured a cure before the illness could take deeper roots within the patient.

Generally speaking, Thornhill *et al*. (2010) stated importantly, the parasite-stress model emphasizes the causal role of non-zoonotic parasites (which have the capacity for human-to-human transmission), rather than zoonotic parasites (that do not), but previous studies failed to distinguish between these conceptually distinct categories. They added that cross-national differences in personality traits (unrestricted sexuality, extraversion, and openness to experiences) and in societal values (individualism, collectivism, sex equality, and democratization) are predicted specifically by non-zoonotic parasite prevalence. Many cases of the illness anxiety have been reported in literature and many of them were related to disorders as enterobiasis (Ja-

in *et al*, 2005); toxoplasmosis/HIV (Mahmud and Abbas, 2009), scabies (Beltraminelli *et al*, 2009); onchocerciasis (Mbanefo *et al*, 2010); toxoplasmosis (Okusaga and Postolache, 2011); breast cancer (Güth *et al*, 2011); schistosomiasis *japonicum* (Jia *et al*, 2011); human pediculosis especially phthiriasis (El-Bahnasawy *et al*, 2012); zoonotic cutaneous leishmaniasis (Morsy, 2013); *Cimex lectularius* infestation (El-Bahnasawy *et al*, 2013), and the chronic Behçet's syndrome (Talarico *et al*, 2015). However, to the best of the present authors' knowledge this may be the first case related to the lymphatic filariasis (Scoragg, 1995; *et al*, 2013).

Conclusion

The early identification of the condition and prompt referral for treatment is imperative for improved overall disease outcome. Physician and infectious disease specialists must be aware of illness anxiety disorder when treating patients with infections or relatives of these patients who may be afraid that they would contract the illness as well.

No doubt, the better understanding of the causative pathogenesis leads to the prevention and treatment opportunities.

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