## Somatic Delusion or Recurrent Pulmonary Embolism? A Case Report

**To the Editor:** Somatic delusions are common, often subtle, mood-congruent manifestations of major depressive disorder with psychotic features.[1] This is a presentation and discussion of a patient with somatic delusions of chest pain that presented a challenge in differentiating thromboembolus from delusion.

***Case report.*** Mr A, a 32-year-old recently unemployed and homeless man with a history of cocaine dependence and major depressive disorder, was transferred from the internal medicine ward (where he was treated for pulmonary embolism [PE] for 1 week) to a dual diagnosis inpatient unit in December 2008 for evaluation and management of depressed mood, suicidal ideation, neurovegetative symptoms, and cocaine dependence.

On our initial evaluation, the patient reported a 6-week history of progressively depressed mood, suicidal ideation, sleep disturbances, weight loss, and guilt. He also reported 10 years of daily cocaine use, but denied use during the month prior to admission. He displayed paranoia and obsessive thoughts, but showed neither perceptual disturbances nor delusions.

We continued anticoagulant dosing: subcutaneous enoxaparin 90 mg every 12 h was administered until the international normalized ratio (INR) was at goal 2.0–3.0; warfarin 5 mg po qhs was administered and continued to maintain therapeutic INR. On hospital day 2, the patient reported chest pain. The vital signs and physical exam were unremarkable. Electrocardiography and laboratory evaluation revealed no abnormalities. The suspicion of pulmonary embolism was low.

Further evaluation revealed paranoia, impaired reality testing, and affective blunting consistent with the psychotic features of a major depressive episode (*DSM-IV-TR* criteria). We initiated aripiprazole (45 mg daily) and citalopram (20 mg daily) therapy. He continued reporting chest pain and displayed the other psychotic signs and symptoms for the next 6–7 days. By hospital day 10, he reported no chest pain, showed no paranoia, displayed more appropriate affect, and reported improved mood. The patient agreed that recurrent PE was unlikely in a well-appearing, therapeutically anticoagulated individual. We discharged the patient on hospital day 14 to an inpatient rehabilitation program.

Medical illness is common in patients with psychiatric disease, particularly in patients with co-occurring substance use disorders.[2] Psychiatrists often evaluate symptoms and complaints in the setting of acute psychosis, which may complicate the diagnostic assessment. Bunce et al[3] showed that most psychiatric inpatients are unable to communicate their physical symptoms adequately with physicians.

The recent diagnosis of PE in this patient increased his likelihood of redeveloping thromboembolus; however, evaluation showed a low likelihood of PE. We reconsidered the new onset chest pain complaint in the setting of worsening paranoia, blunted affect, and impaired reality testing. The clinical data and scenario were consistent with a somatic delusion of chest pain.

It is important to consider the extent to which his recent PE influenced the chest pain delusion. Somatic delusions may be related to gross misperceptions of bodily functioning[4]; this patient's recent experience with chest pain possibly influenced the delusional content.

Finally, whether the dysfunctional hypothalamic pituitary axis in psychotic depression[1] was further influenced (and worsened) by the acute stress of pulmonary embolism and sudden risk of death in a young man remains unknown.

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***Potential conflicts of interest:*** None reported.
***Funding/support:*** None reported.
***Published online:*** February 18, 2010 (doi:10.4088/PCC.09l00787blu).
*Prim Care Companion J Clin Psychiatry 2010;12(1):e1*