

Case Report

HIV/AIDS Phobia Leading to Schizophrenia like Psychosis in a Benign Cutaneous Condition: Pearly Penile PapulesGhanshyam Verma^{1*}, Dinesh Dutt Sharma^{1**}, Ravi Sharma^{2**}, Sandeep Kumar^{3**}, G.R. Tegta^{4*}, Ajeet Negi^{5*}

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Received: 20/10/2016

Revised: 11/11/2016

Accepted: 16/11/2016

ABSTRACT

Pearly penile papules (PPP) are physiologic variant of the normal penis. They are asymptomatic skin colored smooth, measuring about 1-4 mm in diameter and occur in a single or double row on the corona of the glans commonly develop after puberty. Despite being asymptomatic these lesions can cause psychological distress in teenager and young adults considering it as serious concern or sexually transmitted disease (STD) of grave outcome. Many of the men with papules are concerned or worried by their presence and experience embarrassment leading to anxiety, depression and venereophobia. We herein present a case of PPP who developed schizophrenia like psychosis. To best of our knowledge such psychotic reaction secondary to PPP have not been described in the literature.

Key Words: Pearly penile papules, venereophobia, psychosis, sexually transmitted disease

INTRODUCTION

Pearly penile papules (PPP) are physiologic variant of the normal penis and have been described as anatomic formations by famous anatomists Littre' and Morgagni more than 300 years ago. ⁽¹⁾ PPP is frequently seen in dermatological clinics or in sexually transmitted disease (STD) clinics and are a cause for nervousness in teens and young males even today. ⁽²⁾ The occurrence of these lesions may give rise to venerophobia which is foremost reason for seeking consultation. However, professional knowledge among family physicians, urologists and dermatologists about the benign nature of the condition and proper counseling regarding the same will allay the anxiety of the patient. Timely recognition of such condition will avoid unnecessary management. In the present case patient became so much apprehensive about his

lesions that he developed schizophrenia like psychosis.

CASE REPORT

A 41 year married male post graduate farmer presented with a skin colored papular asymptomatic genital lesions for last 7-8 years. He was not worried about them till about 9 months prior to his admission in psychiatry ward when someone told him that these could be due to HIV/AIDS. He visited Dermatology clinic for these lesions. On mucocutaneous examination over the glans penis and coronal sulcus there were multiple well defined skin colored, translucent, papular non tender, non oozy lesions of approximate 0.5 to 1mm in size arranged in multiples rows with no evidence of any secondary changes (figure1). Lesional biopsy revealed keratinized stratified squamous epithelium

showing mild hyperkeratosis, irregular acanthosis without cytological atypia. There was proliferation of stellate and spindled cells around blood vessels with loose damaged collagen bundles and mild lympho-histocytic infiltrate in dermis (figure2). The patient was diagnosed as a case of pearly penile papules. He was reassured regarding the benign nature of illness and explained that no active treatment is required. But patient was not convinced and insisted that his investigation should be done as he had persistent thought in his mind that he may be suffering from HIV/AIDS. He investigated himself for HIV and syphilis on repeated occasions and serology was nonreactive. He used to visit Dermatology clinic frequently for these lesions. He was reassured many times that all his investigations were normal. However, he continued to remain suspicious regarding HIV/AIDS. He denied any extra marital contacts and no similar complains in his wife.

Over the next 3 months, his symptoms gradually increased. He started having difficulty in sleep and would avoid going to his work. He would remain aloof and his social interaction with people decreased. He was again explained about the benign nature of the condition and advised to seek opinion of psychiatrist. He was put on antidepressant Sertraline 50 mg per day and increased upto 100mg per day over a period of two weeks. Patient did not show significant improvement over a period of about one month. He also started saying that people would come to know about his illness and are planning to kill him. He started hearing voices and seeing images which were not heard and seen by others. In addition to antidepressants, antipsychotic medication Tab Risperidone upto 4mg daily in divided doses was added. In about one month there was no significant improvement therefore he was admitted in psychiatry ward. He was managed on oral Haloperidol upto 15 mg daily and clonazepam 0.5mg daily along with supportive psychotherapy. He improved

partially in about 2 weeks but had to be discharged due to death of his 90 years old father. Patient further improved and was nearly asymptomatic for about 1 month of discharge and then he stopped medications on his own.



Figure 1: Multiple lesions in several rows of small, skin-colored or transparent, smooth, dome-topped 1-3mm papules, localized circumferentially around the glans.

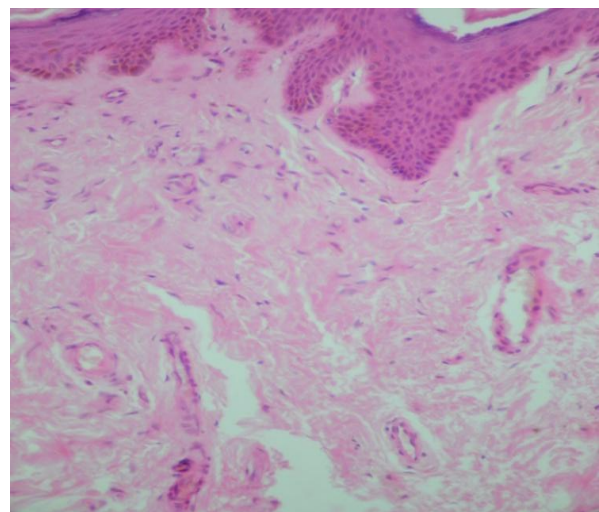


Figure 2: Histomicrograph reveals keratinized stratified squamous epithelium with hyperkeratosis, irregular acanthosis without cytological atypia. Dermis revealed proliferation of stellate and spindled cells around blood vessels with loose damaged collagen bundles and mild lympho-histocytic infiltrate.

In about two weeks of discontinuation of medication he again started having difficulty in sleep. Patient again developed suspiciousness that he is suffering from HIV/AIDS. He also started suspecting that village people are aware about his disease and will kill him. Sometime he used to hold axe/sharp objects in defense. He continued to believe his

thoughts despite given evidence to the contrary. He also suspected that people are conspiring against him. They were misguiding his wife and were asking her to make relationship with them as her husband was suffering from HIV/AIDS. Patient also started hearing voices of village people who are planning to kill him because he is suffering from a disease like HIV/AIDS. He also started seeing images which were not seen by other people around. He started showing decreased appetite and decrease in self care. He stopped doing household activities. Most of the time, he would remain fearful that someone is there around him and will kill him and he started abusing alcohol to overcome the fear. He was readmitted in psychiatry ward.

There was no history suggestive of made phenomenon, catatonic behavior, lethargy, fever, headache, head trauma, seizures, and disorientation. There was no past and family history of medical or psychiatric illness. He was well adjusted pre-morbidly.

General physical examination was within normal limits. No abnormality was detected on laboratory investigations and radiological examination with normal systemic examination. He was managed on haloperidol upto 20 mg per day, Trihexyphenidyl 2 mg daily and clonazepam 2mg twice daily. He improved in about 3 weeks and was discharged and lost in follow up.

DISCUSSION

Pearly penile papules are of frequent occurrence with the incidence reportedly ranges from 14-48% of males. (3) The majority were observed in black, non-circumcised male teenagers and young adults. The numbers of lesions of PPP either decreases or fade away with advancing age. (4) It usually develops after puberty although similar structures rarely have also been observed in the newborn. (5)

Clinically, it presents as asymptomatic lesions in one or several rows of small, skin-colored or transparent,

smooth, dome-topped 1-3mm papules, localized circumferentially around the glans penis occasionally on both sides of the frenulum or in the coronal sulcus. They may spread proximally, distally or laterally but former is the commonest presentation. (6)

The commonest differential diagnosis is genital warts and they may be misdiagnosed as Tyson's glands or ectopic sebaceous glands of Fordyce. The patient is often an anxious adolescent. Histological picture is that of angiofibroma. The lesion is analogous to other acral angiofibromas such as adenoma sebaceum, subungual and periungual fibromas, fibrous papule of the nose, acquired acral angiofibroma and oral fibroma. (7)

Fear of venereal disease, especially in a person who has not recently had intercourse, may be a symptom of a severe depressive condition. Venereophobia is frequently associated with cases of severe endogenous depression. Anti-venereal disease propaganda as the main cause of fear was found in 78 % of patients with venereophobia. (8) Pearly penile papules or milia, or even no lesions at all can be distressing to the patient. Fear and guilt is associated with genital wart phobia. Frequently, the occurrence of these lesions may give rise to venereophobia and thus is a major reason for seeking consultation. When a patient presents with an irrational fear about AIDS or another serious medical condition that impair functioning, it pose a diagnostic dilemma and are difficult to manage. Apart from Anxiety Disorders these patients may have Major Depression with or without psychotic features, Somatoform disorders, Delusional disorder or Monosymptomatic Hypochondriasis. Conversely patients with schizophrenia may have irrational fear of AIDS as one of the central delusion. (9) However AIDS phobia to such an extent leading to schizophrenia like psychosis has not been described in the literature to the best of our knowledge. Although PPP is a benign condition but several therapeutic modalities have been acknowledged; anecdotal reports of

fractionated CO₂ laser, cryotherapy, electrodesiccation, curettage and shave excision are safe, and well-tolerated. ⁽¹⁰⁾

CONCLUSION

Physicians should be able to diagnose this benign condition and avoiding unnecessary medical treatment and finally ease the patient's anxiety by reassuring and educating about this condition. Despite reassurance, PPPs can be a source of significant psychological distress to the patient and his sexual partner. Some patients refuse to accept that they do not have a sexually transmitted disease despite vigorous reassurances as was the case in our patient. For such cases psychiatric consultation should be sought to manage the associated psychiatric morbidity which is the main cause of socio-occupational dysfunction.

Conflict of interest: Nil.

Financial support and sponsorship: Nil

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How to cite this article: Verma G, Sharma DD, Sharma R et al. HIV/AIDS phobia leading to schizophrenia like psychosis in a benign cutaneous condition: pearly penile papules. Int J Health Sci Res. 2016; 6(12):356-359.
