SHORT REPORTS

Phobias complicating treatment of uterine carcinoma

Many people fear medical procedures and sometimes need considerable reassurance from their doctor. Only rarely are they of phobic intensity and lead to avoidance of appropriate treatment but then they constitute a major health hazard. We describe the rapid response of one patient's phobias to behaviour therapy so that urgent surgical treatment could be given.

Case report

A 51-year-old married woman had become phobic of hospitals and medical procedures after several periods in hospital during childhood for pneumonia, minor accidents, and a herniorrhaphy. In adulthood she avoided hospitals, having both her children at home and, on her single antenatal visit, leaving without seeing a doctor after watching another patient having a venepuncture. She also avoided dental treatment and vaccinations. There was no history of other psychiatric symptoms and no family history of phobias.

For four years before we saw her she had had menorrhagia and had lost 19.1 kg. For nine months she had had a serosanguineous vaginal discharge, but despite advice from relatives and her family doctor she refused a gynaecological opinion because of her phobias. Eventually she was brought, unwillingly, by her daughter to the casualty department where she was referred for a psychiatric opinion. Her main phobias were related to having an injection, the sight of blood, and being admitted to hospital for surgery. A behavioural approach to overcome these phobias was outlined to her but before starting treatment she agreed to a gynaecological consultation, which showed an enlarged uterus with a haemorrhagic discharge. Cytology confirmed the clinical diagnosis of uterine carcinoma.

A rapid graded-exposure technique was employed. For the injection phobia this involved the patient initially handling needles and syringes, then, with the therapist demonstrating, injecting these into fleshy inanimate objects (oranges). Next she copied the therapist in making subcutaneous injections and finally allowed venepunctures to be performed on herself. Similar graded approaches were used for her phobias of blood and of entering the surgical ward. After six sessions of about an hour each she was able to enter hospital and undergo the necessary preoperative blood tests and pre-medication. Surgery involved a total hysterectomy and bilateral salpingo-oophorectomy, and histology showed an adenocarcinoma of the body of the uterus with superficial myometrial invasion. The ovaries, tubes, and cervix were normal. Postoperatively she refused a course of radiotherapy but was free of recurrence when last seen seven months later.

The ratings of her phobias, before and after treatment, on a 0-8 scale,¹ are shown in the figure. No other psychiatric symptoms have developed.

Phobia ratings before and after treatment.

Comment

Phobias of this nature have an estimated prevalence of less than 1 in 1000 of the general population.² They are usually acquired in childhood as a result of traumatic experiences and can be regarded as conditioned avoidance responses. Fears and phobias are common in childhood and tend to recover without specialised treatment, but if they persist into adulthood they do not resolve unless treated.³ This report shows that phobias persisting for several decades can be overcome in a few hours' treatment so that previously avoided surgical treatment can be tolerated. We would suggest that most patients

with similar phobias can be helped by referral to a psychiatric department before further medical treatment is sought.

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Requests for reprints should be addressed to Dr G G Lloyd, The Maudsley Hospital, Denmark Hill, London SE5 8AZ.

¹ Gelder, M G, and Marks, I M, *British Journal of Psychiatry*, 1966, 112, 309.

² Agras, W S, Sylvester, D, and Oliveau, D C, *Comprehensive Psychiatry*, 1968, 10, 151.

³ Agras, W S, Chapin, H N, and Oliveau, D C, *Archives of General Psychiatry*, 1972, 26, 315.

Department of Psychiatry, London Hospital, London, E1

G G LLOYD, MRCP, MRCPsych, senior registrar

H G DEAKIN, SRN, RMN, nurse therapist

Thrombocytopenia, haemolytic anaemia, and sarcoidosis

A case of sarcoidosis associated with thrombocytopenia and haemolytic anaemia is described. Sarcoidosis has been reported with one or other of these conditions, though not from Britain.¹⁻³ This seems to be the first reported case in which all three conditions are associated.

Case Report

A 25-year-old man first presented in March 1972 with a three-day history of purpura, haematuria, and epistaxis. There was no history of drug ingestion nor any family history of bleeding disorder. A generalised purpuric rash was the only abnormal clinical finding. Haematological investigations showed: haemoglobin 17.4 g/dl, white blood count $8.5 \times 10^9/l$ ($8500/mm^3$), and platelet count $50 \times 10^9/l$ ($50\,000/mm^3$). Idiopathic thrombocytopenic purpura was diagnosed and a good response to oral prednisolone was achieved.

Seven weeks later, although asymptomatic, he was readmitted to hospital as his haemoglobin had fallen to 10.3 g/dl, and the reticulocyte count was 19%. Further investigations showed: platelet count normal; bone marrow showed considerable erythroblastic reaction, with normal megakaryocytes; median red cell fragility 0.49% NaCl (normal 0.40-0.449%); direct Coomb's test positive; red cell half-life using ⁵¹Cr two and a half days (normal 28 days), and spleen:heart uptake ratio 2:1 (normal 2). In view of the haemolytic anaemia, oral prednisolone was again instituted with gradual return of haemoglobin and blood film to normal within one month. Steroids were then discontinued.

He remained well for a year until May 1973, when he developed a soft tissue swelling over his left shoulder and he was again admitted to hospital. Biopsy showed numerous non-caseating tuberculoid granulomata. Blood count was normal and chest x-ray film showed hilar lymphadenopathy. Mantoux negative (100 TU). Kveim test was positive. No treatment was prescribed. He was discharged and remained well until November 1974, when uveoparotid fever and an enlarged cervical gland appeared. Investigations were as follows: chest x-ray film normal; Mantoux negative (10 TU); Hb 16.1 g/dl; platelets $135 \times 10^9/l$ ($135\,000/mm^3$); reticulocyte count 3.8%; bilirubin 26 μ mol/l (1.5 mg/100ml); Coomb's test negative; platelet antibodies weakly positive; immunoglobulin electrophoresis IgG 13.3 g/l; IgA 5.84 g/l; IgM 0.51 g/l. There was diminished response of lymphocytes to stimulation with PPD (purified protein derivative) and PHA (phytohaemagglutinin). Cervical gland biopsy was consistent with sarcoidosis. No treatment was thought to be required and he left hospital after 14 days. Follow-up has shown no further pathological sequelae.

Discussion

Two cases of thrombocytopenia with sarcoidosis were described