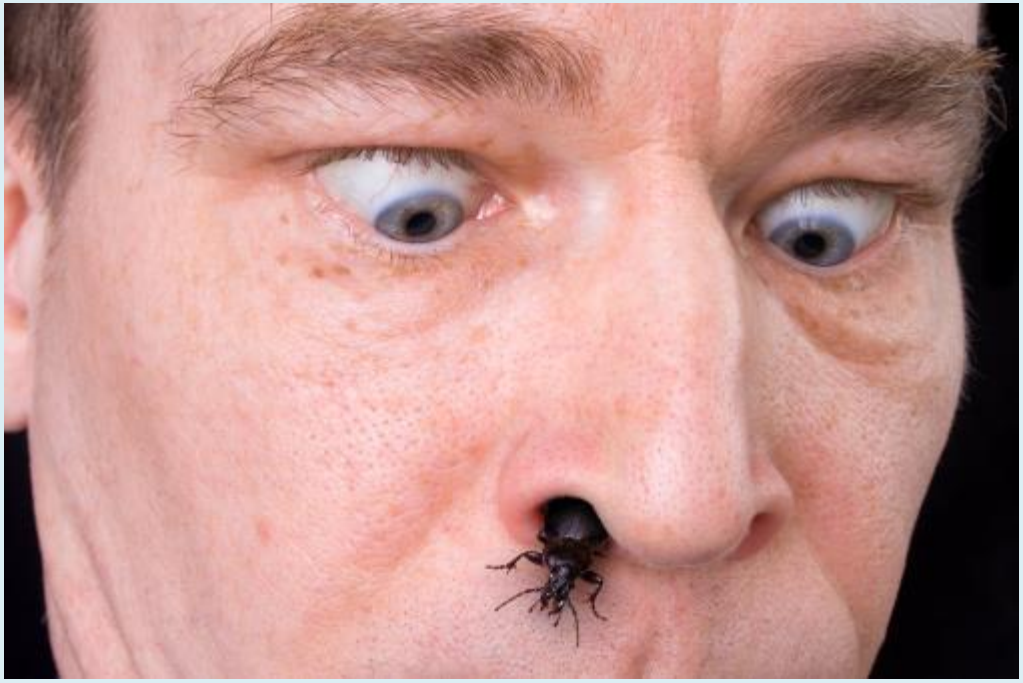
Delusional Parasitosis



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Definition

Fixed, false delusion of infection by parasites, worms, bacteria, or other organisms.

Delusional disorder of the somatic type.

Focus on nonexistent disease and altered perception of bodily sensations.

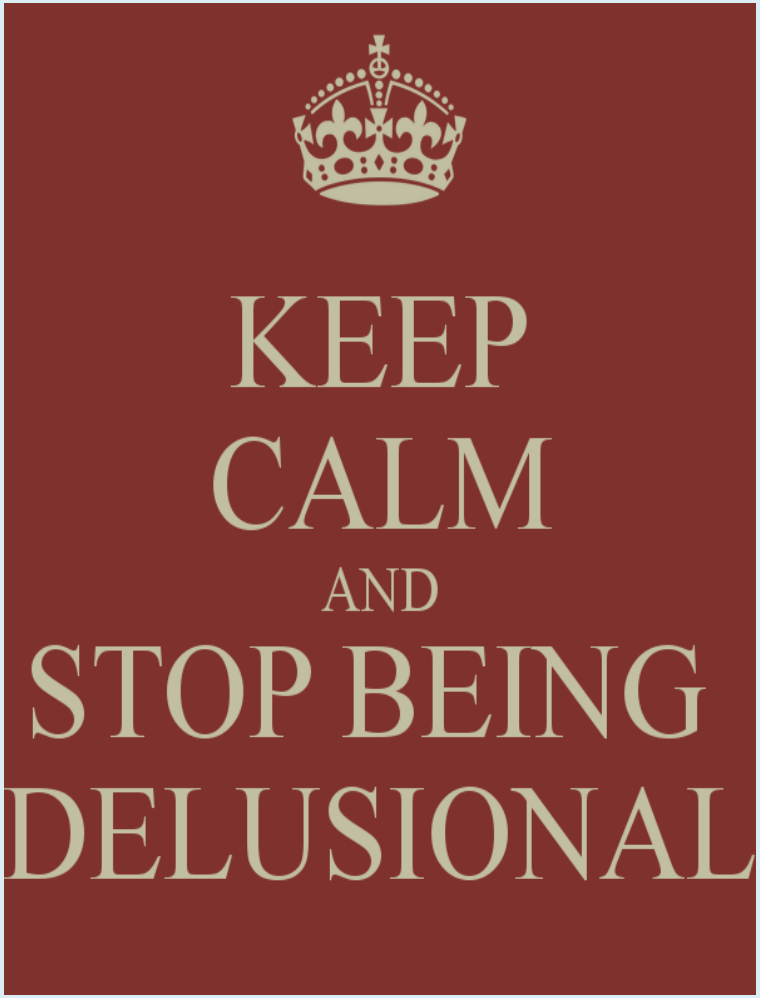
According to DSM-V, five criteria must be met (1):

1. Duration of 1 month or longer
2. Criteria for schizophrenia NOT met
3. No impairment of function, no bizarre or odd behavior
4. Manic/depressive episodes, if present, must be brief relative to the delusional episodes
5. Not attributable to another substance or medical condition

Classification

Primary Delusional Parasitosis
Delusions of parasitic infection are the primary cause of illness.

Secondary Delusional Parasitosis
Delusions of parasitiosis arise from a secondary illness or condition, such as hypothyroidism, cancer, vitamin deficiency, or drug abuse.



Epidemiology

The disease is typically underreported as patients typically do not believe that they are delusional and are reluctant to visit psychiatrists (2).

Mean age of 57 years
Female to male ratio of 2.89: 1
56% Married
33% described themselves as disabled, 28% as retired, 26% as employed.

One population-based study found an incidence of delusional parasitosis in 1.9 cases per 100,000 person-years in Olmsted County, Minnesota from 1976-2010 (3).

Presentation

Patients often present for general medical or dermatologic care.

Signs and symptoms may include:

Pruritus

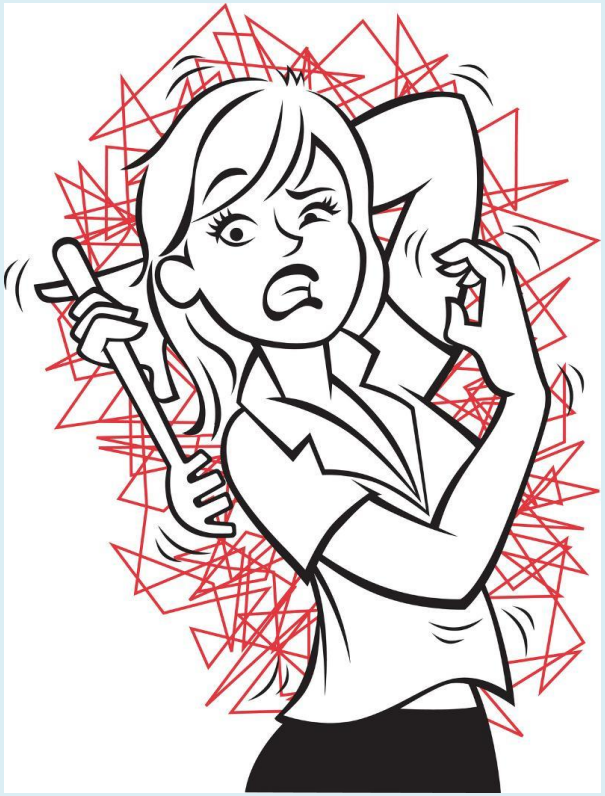
Formication

Pain

Excoriations

Ulcers

Scars

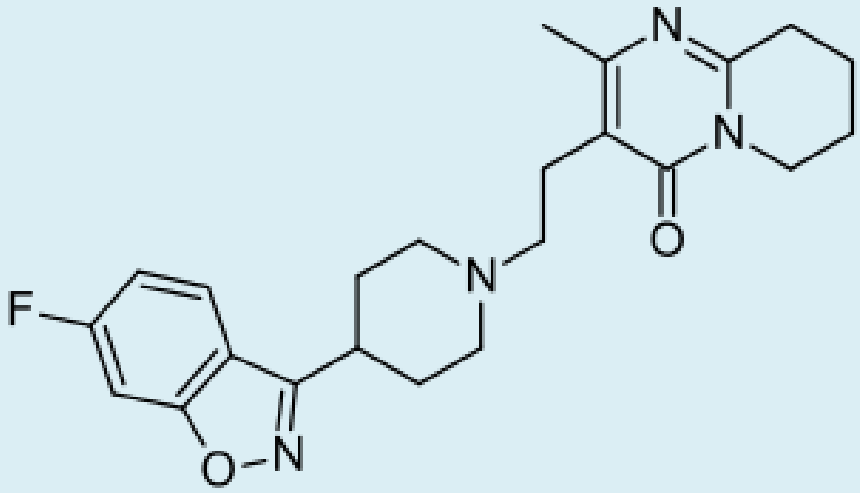


Treatment

Treatment for primary parasitosis is antipsychotic medications.
Treatment for secondary parasitosis is management of the primary medical issue.

Drug of choice is Risperidone, though historically Pimozide has been used (4).
Administer at low dose and titrate slowly.

A strong therapeutic alliance that instills trust is central to clinical management.



Case Discussion

GW is a 48 yo Caucasian male who presented to the ED with complaints of full body burning pain and pruritis. He noted that the pain has been present for over 24 years, and the sensation had extended from his abdomen up to his spine and even into his brain. He attributes his pain to a jock itch that got into his back and traveled through his body.

White count, electrolytes, and liver function tests in the ED came back normal while a plain film of his lumbar spine did not reveal any signs of osteo. UDS did come back positive for MJ and benzos. PE was notable for a candidal infection in the intertriginous area around his groin.

When the ED resident discussed the findings with the patient, the patient became irritated and expressed suicidal ideation, stating that he had numerous firearms at home. He insisted on a skin biopsy despite demonstrating no systemic signs of infection, and he denied fever, chills, nausea, and vomiting. He denied weakness in his arms and legs but admitted to having headaches and full body pain.

Given his suicidal ideation, he was given PO Ativan and taken to the PTU for observation and evaluation.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington, VA 2013.

2. Foster AA, Hylwa SA, Bury JE, et al. Delusional infestation: clinical presentation in 147 patients seen at Mayo Clinic. J Am Acad Dermatol 2012; 67:673.e1.

3. Bailey CH, Andersen LK, Lowe GC, et al. A population-based study of the incidence of delusional infestation in Olmsted County, Minnesota, 1976-2010. Br J Dermatol 2014; 170:1130.

4. De León OA, Furmaga KM, Canterbury AL, Bailey LG. Risperidone in the treatment of delusions of infestation. Int J Psychiatry Med 1997; 27:403.