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Delusional Parasitosis: More Than Just Skin-Deep - A Case Report

Reshma Hegde[1*] and Prinul Gunputh[2]

Affiliation

[1]Hartlepool and Stockton Health, UK

[2]The Green House Surgery, Redcar Primary Care Hospital, UK

[*]**Corresponding author:** Dr. Reshma Hegde, MBBS MRCGP, General Practitioner, Hartlepool and Stockton Health, TS18 1TW, 72 Church Road, Stockton-on-Tees, UK, Tel: 01642 061047, Email: reshma.hegde@nhs.net

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Abstract

Delusional parasitosis is an uncommon disorder and is probably underdiagnosed - several factors contribute including lack of recognition/difficulty in arriving to a conclusion by a clinician, or the reluctance to seek help or even rejection of the diagnosis by a patient. Patients present with pruritus, excoriations, stinging or formication for which no physical explanation can be found. There is the belief on the part of the patient that their skin is infested by insects or inanimate objects. It is estimated that a dermatologist may see one case every 7 years (Suh, 2018). Morgellons disease is a disputed condition which may fall under the umbrella term of delusional parasitosis. In this condition any areas of concern on the skin are believed to contain foreign material, usually coloured fibres. There is often an overlap of delusional parasitosis with other mental health problems such as depression and anxiety. Successful treatment requires a multi-modal approach in the form of medication (usually antipsychotics), psychotherapy and the input of various specialists (dermatology and psychiatry). Primary care - general practitioners in particular - has a central role to play by orchestrating this process so that a satisfactory outcome is achieved.

Keywords: Delusional Parasitosis, Primary Care, Multi-disciplinary Approach.

Background

Mental health issues in primary care are common. Here we present the case of a 56 years old lady with a lesser known problem. Although delusional parasitosis - manifested as an unshakeable erroneous belief of infestation is quite rare [1,2], this case highlights the importance of a proper evaluation of a patient's symptoms, the acknowledgement of their distress, and of close cooperation between primary care, dermatology and psychiatric services for a satisfactory outcome. Written informed consent was obtained.

Case Description

The lady presented to the surgery on several occasions with the description of a 'black mouldy substance' or fibres that would appear on her upper and lower limbs, the sensation of 'hairs' at the back of the throat with associated difficulty swallowing, a 'sticky black discharge' from the nostrils, and the feeling of 'bugs' under her skin. She had a history of depression in her mid-twenties for which she had been on Fluoxetine on and off over the years. There had been historical amphetamine use (exact details unknown). She did not smoke or drink alcohol.

After being made redundant, she decided to relocate and moved in with her mum into council accommodation - which was later condemned due to issues with excess damp. It was then that her symptoms started.

The lady was referred for an opinion to ENT due to her nasopharyngeal symptoms - an array of investigations (including panendoscopy and MRI) was conducted which were all normal.

Due to reflux symptoms, a gastroscopy was arranged from primary care. This did not show any inflammation, but eradication treatment was advised due to her being CLO-test positive. Interestingly, the feeling of formication and the alleged seepage of black mouldy substance continued throughout the course of the investigations and only improved temporarily when she was given eradication treatment. This reinforced her belief in there being an infective cause for her symptoms and led to repeated requests for antibiotics.

Following several further contacts (attendance at either the urgent care centre, GP surgery, or home visits during which she would produce both pictures of her skin and saliva samples, and deny any anxiety), the decision was made to refer her to the community dermatology clinic.

A diagnosis of delusional parasitosis was made at the first visit after careful history-taking and close skin inspection, which only revealed some small excoriations. The diagnosis was shared with the lady and a referral to the psychiatry team suggested.

The diagnosis was initially disputed by the patient and it took another few visits to her usual GP and a referral to a consultant dermatology clinic for her to start accepting it. Olanzapine was recommended from the clinic. Although the lady was not keen on the idea of seeing the psychiatry team when first suggested, the initiation of Olanzapine made her revisit her decision and she agreed to have the required mental health input.

She remains under their care and has been restarted on Fluoxetine to help with her depression. Although there has not been complete resolution of her symptoms, there is more insight on her part and the symptoms are better controlled.

Discussion

The actual prevalence of delusional parasitosis is unknown. It is not thought to be common. It does, however, have a female preponderance and tends to affect people who belong to lower socioeconomic groups [1]. Other psychiatric comorbidities can co-exist, such as anxiety, depression, and OCD [1,2].

Morgellons disease (a condition of controversial existence) - believed by some to be a subset of the above - refers specifically to the presentation where patients believe their skin contains foreign material (e.g. fibres) which they try to extrude and even bring to the consultation in specimen bottles - the "matchbox sign" which is very common in any form of delusional parasitosis. Often these contain clothing fibres, hairs, and dead skin/dried blood [1,3]. In this lady's case, she does have matching skin symptoms, but her associated ENT symptoms make it a possible atypical presentation of Morgellons disease.

This case highlights the importance of careful assessment and getting the patient on board - ideally from the outset [4]. As is the case with medically unexplained symptoms, there is the potential risk of over-investigating, which may reinforce anxiety and delay diagnosis. Acknowledging any distress and impact, keeping investigations to a minimum and timely referral to a dermatologist and/or psychiatrist are important [5,6]. Enquiring about and keeping in mind the premorbid status of a patient can also help with diagnosis [6]. GPs are ideally placed to carry out a holistic assessment of anyone who presents with a mental health problem with physical manifestations or vice-versa. Psychodermatology is an emerging speciality and recognises the mind-skin interaction [7].

In this case, the lady only had mild skin excoriations, but for some people with delusional parasitosis they can engage in more serious self-mutilation to rid themselves of the 'offending' bugs, insects, or foreign material [8].

It is important to screen for a more global psychotic disorder such as schizophrenia, bipolar disorder, or even severe depression in people who appear to have fixed delusions [4,8]. Alcohol misuse and recreational drug use should be explored as formication is quite commonly seen. It is also important to keep other differentials in mind, such as a genuine skin condition that may have been initially missed (e.g. scabies) or an organic medical condition (B12 deficiency; neurological conditions such as dementia or Parkinson's or post-herpetic neuralgia; hyperthyroidism; lymphoma) [4,8].

Once diagnosed, management of the condition can be through antipsychotics (which can also increase insight), psychotherapy, and/or the treatment of any concurrent physical or mental health issues [1,6]. Pimozide (an old typical antipsychotic), which used to be the medication of choice in delusional parasitosis, has been replaced by newer atypical antipsychotics with better side-effect profiles such as Olanzapine and Risperidone. It is estimated that only 1 in 7 patients with delusional parasitosis have antipsychotics either prescribed or recommended by dermatologists [9].

Conclusion

A close alliance between primary care (having an index of suspicion and holistic assessment through a cohesive doctor-patient relationship, which is likely to improve both acceptance and compliance), dermatology (diagnosis) and psychiatry (initiation of treatment and ongoing follow-up) is necessary to manage this condition in a timely manner [6,10].

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