

Delusional parasitosis with alcohol dependence syndrome - A case report

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Abstract

Background: Delusional parasitosis is an uncommon psychiatric illness, and patients usually seek treatment from non-psychiatric medical care. Seen more in women than in men, with usual age of presentation being their 60s. Treatment is by antipsychotics to which patients respond minimally. Here we report a case of a 55-year-old male who responded exceptionally well to typical antipsychotic.

Keywords: delusional parasitosis, alcohol, encephalomalacia, antipsychotic.

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Introduction

Delusional Parasitosis is an uncommon psychiatric illness consisting of false belief of being infested by parasites [1] Also known as Ekbom syndrome, named after neurologist Karl Axel Ekbom [2] Delusional parasitosis can be of primary, secondary or of organic origin. Primary delusional parasitosis consists of a single delusional belief of being infested by parasite [3], secondary delusional parasitosis occurs with other disorders such as schizophrenia, dementia. Organic delusional parasitosis occurs due to causes such as diabetes mellitus, HIV, hypothyroidism [4] Usually patients are seen to injure themselves as they try to remove the parasites (worms) from their skin. In few cases it is also seen that patients collect dust, scab, debris excoriated from skin as evidence to show to their doctor, called as “match box sign” [5] Most often patients are seen to be consulting dermatologist or to physician [6] Mainstay of treatment is by antipsychotics [7], however management of medical condition and organic causes in cases of secondary and organic delusional parasitosis respectively is of importance. In literature, very few cases of dual diagnosis of delusional parasitosis with alcohol dependence syndrome have been reported. Here we report a case of a 55-year-old male who responded exceptionally well to antipsychotic.

Case Report

55-year-old male presented to psychiatry OPD with 4-year history of belief of worms crawling over his scalp and which gradually progressed to belief of worms also crawling over both his arms. In response to this, the patient would try to kill the worms with his thumb and would also believe that the worms died as he was convinced because of the sound produced by his thumb. Patient claims that new worms kept crawling each time he killed old worms. Patient developed disturbed sleep due to the crawling sensation of the worms, hence started to consume alcohol and gradually became dependent on alcohol as it temporarily reduced the belief and sensation of the crawling worms. There was no significant past or family history of psychiatric or neurological illness. Physical examination did not reveal any abnormalities. On mental status

examination patient was calm, cooperative. His attention was aroused and concentration sustained. Delusion of infestation and tactile hallucination was elicited and he had an anxious cognition, was oriented to time place and person and insight appeared to be of grade 2. Serial evaluation showed hallucinatory behaviour of killing the words with his thumb. Patient was admitted and blood investigations were carried out, i.e complete blood count, renal function tests, liver function tests, serum electrolytes, thyroid function tests, VDRL, markers for hepatitis and HIV which were within normal limits. Computed tomography of the brain showed encephalomalacia of bilateral frontal superior gyri. Dermatologist opinion was taken to rule out any dermatological condition. He was subsequently diagnosed as a case of persistent delusional disorder with alcohol dependence syndrome, according to ICD 10. Patient was initiated on Tab Pimozide 2mg and gradually built to 4mg to which patient responded significantly. Simultaneous detoxification for the uncomplicated alcohol withdrawal was also carried out. He was discharged in 6 days. On follow ups patient is seen to have significantly improved and also resumed his work, has also remained abstinent from alcohol.

Discussion

Our patient here had delusional parasitosis with alcohol dependence syndrome which is an uncommon presentation. Current literature also suggest a female preponderance and an older age of onset which is not in our case [8]. Literature also suggest that these patients usually seek treatment primarily from either physicians or dermatologist, where as our patient visited to psychiatrist primarily even though there was a delay to seek treatment. [6]

Another striking feature in this patient was the late onset of alcohol dependence which was secondary to the delusions. He totally quit alcohol once the delusions subsided.

Empathy and good rapport were maintained throughout the management of this patient. As few medical illnesses are known to accuse similar delusions, detailed medical examination and relevant investigations were carried out. Our patient responded very well to typical antipsychotic i.e to tablet pimozide which is very well known to be the drug of choice for delusional disorder. To conclude, delusional parasitosis often present to non-psychiatric medical care. Multiple dermatological consultations might be sought leading to further distress and depression leading to more complex clinical scenario. Better awareness of the disorder by general physicians might lead to early referral to psychiatrists and to better management, reducing the disability in such patients.

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