A Case Report on Delusional Parasitosis and Tactile Hallucinations

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Abstract: **Delusional parasitosis, also known as Ekbom's syndrome, is a rare psychiatric disorder characterized by the false belief of being infested with parasites. This delusion is often accompanied by tactile hallucinations, where patients experience sensations of crawling, itching, or biting on or under the skin. These symptoms can lead to significant distress and self-inflicted skin damage.This report discusses the case of a 71 year female patient who developed delusional parasitosis. The patient presented with a firm belief in a parasitic infestation and reported tactile hallucinations of crawling sensations, despite multiple negative dermatological evaluations. Her condition was further complicated by visual hallucinations of "black dots" she identified as parasites. After much resistance, she accepted psychiatric treatment, including low-dose risperidone, and supportive counseling. The case highlights the diagnostic and therapeutic challenges in managing delusional parasitosis, a condition often perceived by patients as dermatological rather than psychiatric. A multidisciplinary approach, involving both dermatology and psychiatry, is crucial for effective management. This case shows the importance of early psychiatric intervention and the need for a patient-centered approach in treating delusional parasitosis, particularly when tactile hallucinations are present. Pharmacological treatment with antipsychotics, combined with supportive therapy, is essential for improving patient outcomes.**

Key words: **Delusional Parasitosis, Ekbom's syndrome, tactile hallucinations**

INTRODUCTION

Delusional parasitosis, also known as Ekbom's syndrome, is a rare psychiatric disorder where individuals falsely believe they are infested with parasites. This delusion is often accompanied by tactile hallucinations, where the person feels sensations such as crawling, itching, or biting on or under the skin[1][2][3]. These tactile sensations can be intensely distressing and may lead to self-harm as the individual attempts to rid themselves of the perceived infestation. The condition is most commonly seen in older adults and can be associated with various psychiatric and medical conditions, including schizophrenia, depression, or substance abuse. The cause of delusional parasitosis is not entirely understood, but it is thought to involve a combination of neurobiological and psychological factors[4][5]. Treatment options include Second-generation antipsychotics such as Risperidone, Olanzapine, and These are often preferred due to fewer side effects compared to first-generation antipsychotics. Alternative therapies include Pimozide Antidepressants such as Sertraline, Escitalopram and Mood stabilizers such as Lithium, Valproate is challenging, as patients often reject psychiatric intervention, insisting their condition is dermatological rather than psychological or psychiatric[6].

CASE PRESENTATION

The Client, a 71-year-old female patient, presented with a firm belief that she was infested with small insects. This belief began approximately eight months ago, when she suspected that her neighbhour is trying to harm her by sending some insects to harm her and her family members. She reported the feeling of "things crawling" under her skin and seeing small, black dots that she identified as "parasites." Despite multiple visits to dermatologists and several rounds

of antiparasitic treatment, no evidence of infestation was found. However, the patient remained convinced of the presence of parasites, leading her to frequently scratch her skin, resulting in excoriations and secondary infections. Upon psychiatric evaluation, the patient exhibited no signs of a formal thought disorder but was present with the idea of infestation. She denied any auditory or visual hallucinations beyond the sensation of crawling insects and the occasional sight of black dots. No other delusional beliefs were reported. Her medical history was significant for hypertension and it was well controlled with the current medication of CILACAR 10mg(CILNIDIPINE) in the morning. The patient had no prior psychiatric history, and there was no history of substance or drug abuse. The patient was initially resistant to psychiatric treatment, insisting that her problem was purely dermatological. After much discussion, she agreed to try a low-dose antipsychotic, Risperidone(T.RISPIL 1mg HS), along with regular follow-ups. Supportive therapy such as patient centered counseling was also offered to address her recent stress associated with the condition and stress management techniques were discussed to help alleviate her anxiety.

DISCUSSION

Delusional parasitosis is a complex condition that straddles the boundary between dermatology and psychiatry. The patient's case highlights the challenges in diagnosing and treating a condition that the patient does not perceive as psychiatric. In delusional parasitosis, the primary delusion is the belief in a parasitic infestation, but tactile hallucinations often play a significant role in reinforcing this belief. The Client's sensations of crawling and itching, coupled with visual hallucinations of "black dots," supported her fixed belief, making it difficult for her to accept a psychiatric diagnosis. This case also underscores the importance of a multidisciplinary approach. Collaboration between dermatologists and psychiatrists is essential in managing delusional parasitosis, especially given the patient's likely resistance to psychiatric intervention. Pharmacological treatment, particularly with antipsychotics, remains the cornerstone of therapy, although patient compliance is often a hurdle. Risperidone was chosen for its efficacy in treating delusional disorders with relatively fewer side effects. Non-pharmacological interventions, including cognitive-behavioral therapy and supportive counseling, plays a crucial role in helping patients cope with the distressing symptoms and improving their insight into the disorder.

CONCLUSION

This case of delusional parasitosis complicated by tactile hallucinations illustrates the challenges in managing a psychiatric condition presents with primarily dermatological complaints. The patient's firm belief in an infestation despite all evidence to the contrary, coupled with the psychological distress highlights the need for a compassionate, multidisciplinary approach to treatment. Early psychiatric intervention, combined with consistent support and monitoring, is essential for improving outcomes in patients with delusional parasitosis.

RECOMMENDATIONS

Regular psychiatric follow-ups should be continued to monitor the efficacy of risperidone and to adjust the dose as necessary. Dermatological follow-ups should also be maintained to address any skin damage. Continue counseling and cognitive-behavioral therapy (CBT) to help the client develop coping mechanisms for anxiety and delusional thinking. Ongoing education about the nature of condition should be provided in a gentle and non-confrontational manner, with an emphasis on the connection between stress and symptoms. Engage the patient's family members to provide support and reinforce the importance of adhering to treatment, including the psychiatric aspect. Introduce relaxation techniques, such as mindfulness or meditation, to help the patient manage stress, which may help to reduce the intensity of tactile hallucinations. This case demonstrates the importance of a holistic approach to treatment, considering both the psychological and physical aspects of delusional parasitosis.

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