ORIGINAL CONTRIBUTION

New Findings in Delusions of Parasitosis

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ABSTRACT

Two new cases are presented with delusions of parasitosis. Both were women, one middle-aged and one elderly, and exhibited classic symptoms of parasites and "strings" in the skin indicative of Morgellons disease. Each had an additional psychiatric disorder: drug addiction to cocaine and senile dementia. They also illustrate the difficulty encountered by the dermatologist in providing adequate therapy because of resistance to psychiatric referral as well as to standard accepted medication. Newer psychotropics, such as risperdal and lexapro, show promise in helping these patients and add to the therapeutic armamentarium of pimozide. (*SKINmed.* 2012;10:72–74)

This is the first report of two patients with both the classic features of Morgellons disease and delusions of parasitosis at the same time. Delusions of parasitosis are a disease characterized by an encapsulated delusion that the body is infested with parasites, usually insects or bugs in or on the skin. Patients with Morgellons disease report strings coming out of the skin. It is thought to be a subset of delusions of parasitosis. One of the two patients exhibited the previously reported finding by this author of the precipitating life factor that incited the disease, which was abandonment by her lover.[1]

CASE 1

A 44-year-old African American woman presented with the complaint of "stuff crawling on the skin." She described in great detail that strings were coming out of her eyelids and eyelashes, causing her great distress. She felt the need to constantly brush off the strings from the eyes with her hands, which caused her hands to feel irritated as well as her face. In addition, she described that "parasites come out of my ears." She said the parasites made a fizzing noise in her ears, which she described as resembling the fizz sound of soda poured into a glass.

She indicated that the onset of the symptoms began approximately 1 year previously, which coincided with abandonment by her lover of 6 years as well as the loss of her job as a social worker. Her medical history revealed that she had been addicted to crack cocaine as well as heroin in the past. She admitted to smoking crack as recently as 3 weeks before the initial visit. In addition, she was taking methadone, which was prescribed by the hospital's mental health clinic.

She reported to be in otherwise good health expect for an allergy to iodine. After the relationship breakup, she was briefly treated for depression with an antidepressant by a mental health clinic. She refused to return to the mental health facility due to her perception of stigma over mental illness.

Physical examination revealed mild scaling of the scalp consistent with mild seborrheic dermatitis, scaling of palms and soles, and dystrophic toe nails. The remainder of the physical examination including the face, back, trunk, arms, and legs were within normal limits.

Results from all laboratory tests including complete blood cell count and complete metabolic panel were within normal limits. The patient refused to have a urine toxicology examination.

Treatment was initiated with fluocinolone solution to the scalp as well as the head and shoulders, ciclopirox cream twice a day to the feet for tinea pedis, and permethrin cream to the body for itch.

She had previously used Sarna lotion and hydroxyzine 25 mg every night at bedtime and had her apartment exterminated, with no relief. At the first visit she was started on escitalopram 10 mg every night at bedtime. She refused a psychiatric consultation.

At the second follow-up visit 2 weeks later, the patient reported no improvement in symptoms and, if anything, reported that the "strings" were worse than ever and the parasites were crawling out of her ears and onto her face. She was very angry that she was prescribed a selective serotonin reuptake inhibitor (SSRI). Examination revealed no change compared with the first visit.

The patient was encouraged to ventilate about her problems. Lidocaine/prilocaine cream was prescribed for dysesthesias and feelings of formication and she was encouraged to increase the dose of escitalopram to 20 mg at night.

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CASE 2

A 90-year-old woman was referred from a major medical dermatology center with a diagnosis of delusions of parasitosis. On the first visit she described worms and strings coming out of her body including the skin, eyes, and mouth. She reported the onset as September 2009 following a bout of diarrhea during the summer that lasted for 2 months. She was treated with albendazole by a noted parasitologist for trichuris infection. The diarrhea abated with the treatment.

By September 2009, she had described worms and strings coming out of her body, causing her great discomfort. She first went to her primary care physician at the medical school center. He examined the material she brought and told her there were no parasites or strings but only mucous. This angered her and she refused to return to the physician. She brought a drawing of the worms and strings on her first dermatology visit (Figure 1).

Examination revealed a thin elderly woman in no acute distress whose stream of thought was verbose and rambling. The skin showed a reddened and ulcerated area on the right thigh (Figure 2). The remainder of the physical examination was within normal limits. Results from laboratory tests were within normal limits. The patient was given mupirocin ointment for the ulcer and ammonium lactate 12% lotion for the skin on the body and was reassured there was some possibility that the disturbance might abate.

On follow-up 2 weeks later, she claimed the parasites had started in June 2009, contradicting her previous statement that they had started in September 2009. She now claimed slight improvement with the treatment. There were, however, new lesions on the right thigh (Figure 3). Once again she was unclear about whether these resulted from the parasites. She indicated that the strings and worms were coming out of her ears, eyes, nose, and skin on the face.

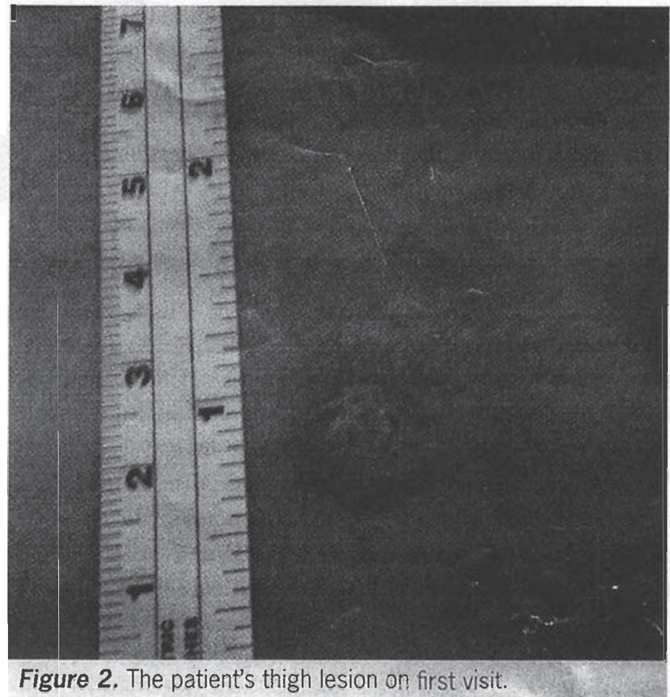

Figure 2. The patient's thigh lesion on first visit.

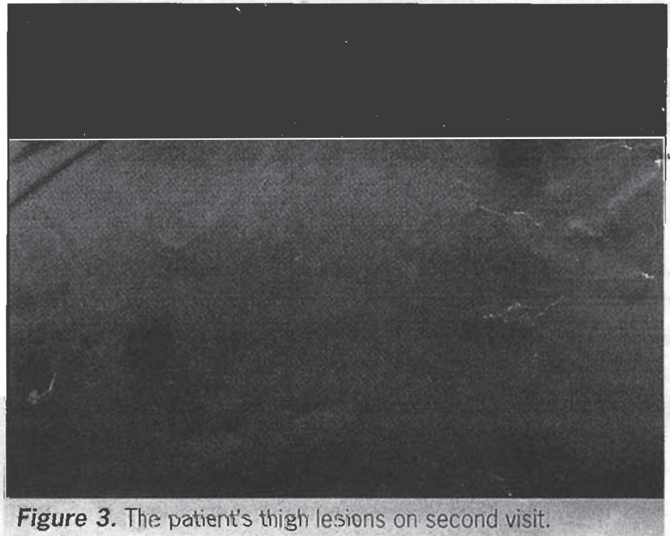

Figure 3. The patient's thigh lesions on second visit.

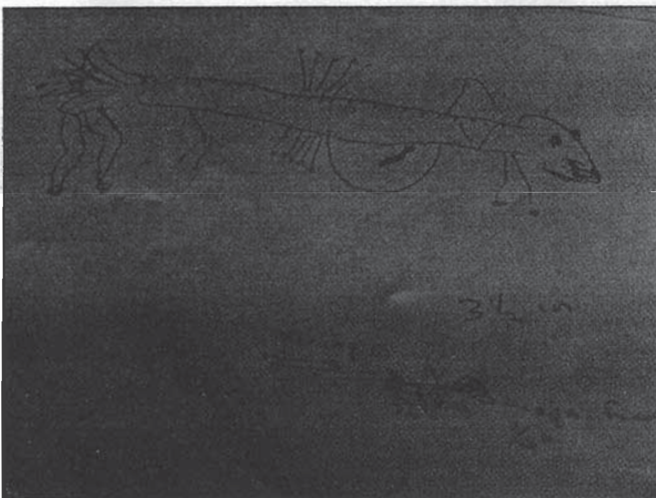

Figure 1. The patient's drawing of string and parasite coming out of her skin.

She was encouraged to take doxepin 25 mg at night and continue with ammonium lactate 12% lotion and mupirocin ointment. She was also encouraged to ventilate about her multiple social problems, including her family, her will, and her eating problems. She said she weighed 87 pounds because she was unable to eat any carbohydrates since she believed the parasites lived on sugars. She said she was in the process of getting assistance in daily-living activities at home.

On third follow-up, she said she felt considerably better (2 weeks after second visit) using emollients. She did not mention parasites, but said the problem was improving. She was encouraged to seek psychologic or psychiatric counseling but was not accepting of this suggestion. She said she was going to make an appointment for a visit at a nearby medical center geriatric unit to help her with nutrition and memory problems. She was encouraged to take doxepin at bedtime and to use emollients.

DISCUSSION

These cases are the first to exhibit findings of Morgellons disease and delusions of parasitosis at the same time. Morgellons is a pattern of dermatologic symptoms very similar, if not identical, to those of delusions of parasitosis, and many patients with Morgellons are diagnosed with another psychosomatic illness.[2] In delusional parasitosis, patients hold a delusional belief that they are infested with parasites. They may experience formication, the sensation that insects are crawling under the skin. It is a common symptom in cocaine abusers as well. Individuals who experience this condition may develop elaborate rituals of inspection and cleansing to locate and remove parasites and fibers, resulting in a form of self-mutilation; they injure themselves in attempts to be rid of the "parasites" by picking at the skin, causing secondary lesions. Continuous picking of the lesions prevents healing. Patients with delusional parasitosis often present at the doctor's office with what physician's term the *matchbox sign*, a medical sign characterized by the patient making collections of fibers and other foreign objects supposedly retrieved from the skin, and, because of "unshakeable delusional ideation," strongly reject diagnoses that do not involve parasites. The Morgellons Research Foundation, a nonprofit organization, considers Morgellons to be a newly emerging infectious disease, but the medical community disagrees, noting that the described symptoms of Morgellons are associated with the psychotic disorder known as delusional parasitosis.[2]

Due to the second patient's age, it was deemed inappropriate to give pimozide or treatment with an SSRI medication since sudden death in the elderly has been reported.[3] The treatment plan was to gain the patient's confidence before attempting to refer her for psychologic or psychiatric care, since there did not appear to be any insight on her part at the first 2 visits.

Therapy is often unsuccessful because many patients, such as those reported here, refuse consultation with a psychiatrist either because they believe the problem is organic or because they fear mental illness and the stigma of psychiatry. In extremely severe cases, suicide has been reported, illustrating the urgency of corrective medication and prompt psychiatric referral.[4] Standard treatment with pimozide risks substantial side effects.[3] This has led to trial with additional psychotropic agents. Recent success has been reported with the use of risperdal[5] and olanzapine.[6]

Nowhere have these diseases been more graphically illustrated than in the Oscar-nominated 2010 film "Black Swan" wherein the heroine played by Natalie Portman suffers from the delusion that parasites and strings are coming out of her skin. This is a must-see film for dermatologists and psychiatrists alike.

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