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Delusional parasitosis presenting as “Folie a Famille”: Case report

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ABSTRACT

Delusional parasitosis (DP), which is also known as Ekbom syndrome, is a rare delusional disorder where the patient is convinced of being infested with worms, insects, parasites or bacteria, while no objective evidence exist to support this belief. Because patients believe that the disorder is due to the physical cause, they usually apply dermatologists or family practitioners for treatment at first, and referred to psychiatrists after their symptoms become more prominent. Somatic delusion is shared with one or more members of a family (folie a deux-trois) or by all members of the family (“folie a famille”) in 5-15% of DP cases. Today, second generation (atypical) anti-psychotics are used in the treatment. In this paper, a primary case of DP presenting as shared psychotic disorder (SPD) in the form of “folie a famille,” clinical picture and treatment process is presented. We used olanzapine for treatment of primary case. Her symptoms ceased within 3 months and other family members became asymptomatic without any medication. She was still asymptomatic at the end of 4 months. This case report is important in terms of showing psychosocial impact of DP and SPD comorbidity and to create awareness about this disease among health care providers.

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INTRODUCTION

Delusional parasitosis (DP), also known as Ekbom’s syndrome or dermatophobia, is usually a monosymptomatic, hypochondriacal psychosis and is classified as somatic type delusional disorder in today’s modern classification systems. DP may develop primarily or may occur secondary to medical, neurological or psychiatric disorders. DP may also occur in amphetamine and cocaine intoxication or as a side-effect of other drugs [1-3].

DP’s clinical appearance may be in different forms. Complaints are usually associated with skin and occasionally gastrointestinal infestation. The common symptoms can be considered as itching, stinging type pain, burning, matchbox sign, which is characterized by bringing the patient’s various body parts (nail, hair etc.) to the doctor in a small container [1,4]. Except for the presence of a fixed, encapsulated belief (delusion), DP patients are generally suitable view. DP patients may describe hallucinations (tingling, itching, stinging, etc.) often compatible with delusions. In rare cases, auditory hallucinations and self-injurious behaviors (abnormal cutting of the nails, scraping hair and body hair or applying pesticides to the body)

is observed. Dermatologic symptoms vary according to the period of diagnosis [5-7].

In this paper, a DP case presenting as “folie a famille” is presented and clinical signs, diagnostic evaluation and treatment processes are discussed.

CASE REPORT

A 32-year-old married, military officer, female patient was referred to dermatology clinic with a fixed belief of being infested with lice and nits, itching, and widespread skin lesions. On dermatological examination, on the scalp, egzamatized dense plaques due to chronic scratching were observed. In addition, on the patient’s neck, arms, genital and anal regions, some excoriated lesions covered by scabs, compatible with irritant contact dermatitis, were found. Pediculosis (head lice) was not detected. On psychiatric examination, she was negativist, unwilling to co-operate, her speech rate was slow and there was no spontaneity. She was giving defensive and circumferential responses to questions posed. Her affect was irritable and the mood was anxious. In her thought content, there was somatic delusion regarding the presence of lice

and nits that they spread herself and her family, they colonized in her body, they bite, they damage her. She had no insight on the situation and judgment was impaired. Mental capacity and other cognitive functions were evaluated as normal. There was no history of psychiatric illness.

According to the story, the idea that she was infested, has started 4 months ago, after she was warned due to a head lice incident in her child's kindergarten. Immediately after this alert, the patient started to think that the child is infested from kindergarten and head lice spread whole family. She had shaved off her own hair as well as child's hair. She had used many lice medications, home disinfected with chemicals, but she still was thinking that lice not disappeared. She was plucking some skin parts from her own body and child's scalp, genital-anal region, which she calls evidence of parasites, and saving in a box. She was telling that doctors did not believe her, not understand anything at all, and they could not cure her. On examination, the patient's 4-year-old daughter, mother and father, also reported that they may be infested with lice, they have itchiness on their body and they would not benefit of the treatments applied.

Psychiatric interviews were conducted on primary case and her parents with the help of Mini International Neuropsychiatric Interview-Plus. The primary case was diagnosed as somatic type delusional disorder, there were not any psychopathology observed in parents. Complete blood count and biochemical tests (serum liver and renal function tests, thyroid hormones, electrolytes, Vitamin B12 and folate levels, urine and stool sample examination, urine toxicology) were within the normal limits. Electroencephalography and computerized tomography evaluation came within normal limits. She had no history of drug abuse, neurological or psychiatric disorder and treatment with psychotropic drugs. There was no other underlying organic or functional disorder.

Mother, 53-year-old housewife, has been living with her daughter since birth of grandchildren nearly 4 years due to groom's frequent business travel. She said hardly talk to anyone outside the family. Mother had no medical or psychological disorder. Depending on to scratch there were viewed **excoriate** eczematous lesions on the scalp and eyelids.

Father is 57-year-old retired officer. It was learned that he was one introvert, hardly to establish social relationships and rarely met with close relatives. He was on hypertension treatment for 7 years. Father had no psychological disorder.

Patient's husband is 37-year-old naval officer, has no psychiatric symptoms and not affected.

Topical antipruritic and emollient therapy with steroid creams and oral anti-histamines were applied for skin lesions of the primary case and her mother. After establishing a therapeutic alliance, the primary case was given treatment with olanzapine 5 mg/day and was increased to 10 mg/day within 2 weeks. Her symptoms were reduced markedly within 3 months. Anxiety was disappeared, sleep was improved, visual and tactile hallucinations were much reduced and delusions have

been regressed into draft. At the end of the 4th month, the patient was asymptomatic. The symptoms of the father and mother completely disappeared within the first month after hospitalization of primary case.

DISCUSSION

Women are affected more often than men. The incidence of DP has been increased with age in women; in patients before age 50, female/male ratio of DP is 2/1, while the ratio in the group of patients aged 50 and over is 3/1 [8,9].

Etiopathogenesis of DP was unclear and triggering factors are not always possible to determine. However, these might include one of the family member's death, flood, accident, in touch with people infested with parasites and travel to less developed countries [1]. In this patient, a case of head lice in the child's kindergarten might have triggered DP.

Somatic delusion is shared with one or more members of a family (folie a deux-trois) or by all members of the family (folie a famille) in 5-15% of DP cases. In the vast majority of cases, when primary case has been improved with treatment, symptoms of the secondary cases disappear spontaneously [10-12]. Gralnick has defined shared psychotic disorder (SPD) as "relationship psychosis," in which delusional thought and/or abnormal behavior is transferred from one person to another as a result of the close relationship [13]. Dewhurst and Todd stated that there should be three criteria for the diagnosis of SPD as follows; to be in very close contact of partners, to have similar or identical delusion content and to share, endorsement or acceptance of each other's delusions [12-14]. In our primary and secondary cases, all these criteria are seen to be present. Still, the emergence of the disorder in a child is associated with the occurrence of disorder in the family system, and this is consistent with the literature. SPD is mostly seen in adults. Children usually appear to be involved in SPD involving the entire family system [15].

Although a typical antipsychotic, pimozide has been used formerly as the first-line option in the treatment of DP, current treatment algorithms proposes the atypical antipsychotics as first order options [2,5,6,16-18]. Among those most commonly used atypical antipsychotics, partial (72%) or full remission (69%) has been reported with risperidone and olanzapine [16].

CONCLUSION

This case report is important in terms of showing psychosocial impact of DP and folie a famille (SPD) comorbidity and to create awareness about this disease among health care workers. Establishment of a strong therapeutic alliance would increase the likelihood of compliance with antipsychotic treatment in DP patients [15].

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