'Bugs in my skin': What you should know about delusional infestation

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Patients with delusional infestation (DI) falsely believe that they are infested with tiny infectious agents—typically vermin, insects, or small animals—that crawl on, in, or under their skin, leaving marks and building nests.[1] Patients often describe the pathogens on the skin of hands, arms, feet, lower legs, scalp, or genital areas. They state the pathogen is difficult to diagnose and usually is contracted by human contact. Most patients with DI engage in intensive, repetitive, and often dangerous self-cleansing to get rid of the pathogens, which results in skin lesions.[1] Less often, patients believe they are infested with bacteria or viruses.[1]

The typical DI patient is a middle age or older female with few social contacts, no psychiatric history, and normal cognitive and social function.[1] Geriatric patients with dementia and vision or hearing impairment who live in a nursing home may develop DI; it also may be seen in geriatric patients with vascular encephalopathy.

What to consider

First rule out a genuine infestation by referring your patient for dermatologic and microbiologic testing. Order basic laboratory tests to assess inflammation markers—complete blood cell count, erythrocyte sedimentation rate, C-reactive protein, electrolytes, liver function, thyroid-stimulating hormone, and fasting glucose.[1] Suggest a cranial MRI to rule out a brain disorder. Also, perform a urinalysis for cocaine, amphetamines, or cannabinoids, which can cause DI.[1] Rule out medical conditions that are associated with pruritus and psychiatric symptoms, including endocrine, renal, hepatic, rheumatoid, and nutritional conditions.

Treating DI patients

Collaborate with a dermatologist, microbiologist, and primary care physician because these clinicians can deliver medical interventions, such as treating skin lesions and prescribing non-sedating antihistamines to alleviate pruritus. The ***Table (page E2)***[1] offers other suggestions for managing DI patients.

Pharmacotherapy. Although high-quality evidence supporting antipsychotics for treating DI is lacking, olanzapine and risperidone are considered first-line agents; haloperidol and perphenazine also are recommended.[1] Response and remission rates are similar with typical and atypical antipsychotics and the median onset of efficacy with antipsychotics is approximately 1.5 weeks.[1,2] Antidepressants—including escitalopram, sertraline, mirtazapine, and venlafaxine—have been shown to effectively treat DI.[3] In treatment-resistant cases, pimozide and electroconvulsive therapy have been used.[1]

Psychotherapy is effective for only 10% of DI patients.[4]

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Table

Treating patients with DI: What to do and what to avoid

Do's	Don't
Do acknowledge and empathize with your patient's concerns	Don't try to convince your patient he or she is wrong about the self-diagnosis
Do perform a thorough physical exam and diagnostic investigation	Don't use words such as "delusional" or "psychotic"
Do paraphrase symptoms as "sensations" or "crawling" instead of reinforcing or questioning them	Don't start psychopharmacology until you establish rapport with your patient
Do indicate that symptoms could be secondary to overactivity of the nervous system or "unexplained dermopathy"	
Do suggest that antipsychotics may help reduce your patient's distress and itching	

DI: delusional infestation

Source: Adapted from reference 1

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