Letters to Editor

Treatment of Delusional Infestation with Olanzapine

Sir,

Delusional infestation also known as Ekbom's syndrome is an uncommon psychiatric condition, in which the patient usually identifies the offending parasites as insects, bugs, worms or rarely bacteria.[1] Delusional infestation is included as Delusional disorder of the somatic delusion type in psychiatric classification, as per DSM-IV-TR.[2] These patients usually visit Dermatology Clinics for treatment. Although the disorder is primarily a psychological one, the patient may visit the emergency care physician, entomologist or the even pest control officer. We hereby report such a patient who responded successfully to olanzapine.

A 62-year-old male from an urban background presented with a history of insects 'crawling' over his upper half of the body. The patient had this problem since many years, when he first noted 'insect movements' on vertex of his head. Slowly, the 'insects' spread over his whole scalp and then descended onto the face and trunk. At the time of presentation, the patient was bald (androgenetic alopecia). He had earlier consulted many doctors, including dermatologists, emergency care physicians, and faith-healers. He complained of irritation due to 'the insects' movement' associated with itching. There was also a complaint of occasional 'running' of insects. On mucocutaneous examination, scratch marks and generalized dry skin were noted. Although no insects could be demonstrated, the patient's explanation was that the "insects were too small to be seen by naked eye". He was a known type 2 diabetic, taking tablet metformin 500 mg twice a day and was well-controlled (FBS = 93 mg / dL; PP2BS = 134 mg / dL). There was no history of alcohol abuse, tobacco use or any other substance abuse. The patient's routine and special investigations (complete blood count, liver and renal function tests) were within normal limits. In view of his classic history, a diagnosis of primary delusional infestation was made. He was prescribed a low dose of atypical antipsychotic, olanzapine 2.5 mg, at night daily. The dosage schedule was increased to 10 mg / day in eight days. For dry skin, use of plain coconut oil after bath, as a moisturizer, was advised. The patient began to show improvement by the fourteenth day. Within two months, the patient stopped complaining of insects crawling around his body. The dose of olanzapine was tapered off slowly and patient was maintained on 5 mg / day. The patient came for regular follow-up, and at present he is in full remission.

As already stated, the patient of delusional infestation usually does not present to a mental health professional, and in a study from Argentina, a psychiatric referral was possible only in one out of 12 patients.[3] This fact certainly has implications for the management of these patients by other specialists. Psychotherapeutic strategies are usually not effective and may be counterproductive as well. Treatment with second generation antipsychotics, for example, risperidone, olanzapine, aripiprazole, amisulpride, ziprasidone,and quetiapine, is quite effective. The usual medication for the condition used earlier was a typical antipsychotic, pimozide, but the high risks associated with it, like extrapyramidal side effects, tardive dyskinesia, cardiac arrhythmias, and hepatic drug–drug interactions (mainly via CYP3A4), particularly in the geriatric age group, did not justify its use.[1] As early as 2006, Meehan *et al.* suggested olanzapine as a first-line therapy for delusional infestation, without specialized monitoring regimens,[4] and in our index report, the patient responded with olanzapine. Our patient is still maintained on a low dose of olanzapine, as in up to one-fourths of the patients, relapse may occur within four months of stopping the treatment.[5]

Our case report suggests more such research in this area, and a better coordination between dermatologists and mental health professionals is the key in the successful management of this population of patients.

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