Delusional Infestation: A Case of Ekbom Syndrome in an HIV-Infected Patient

To the Editor: Delusional infestation, also known as Ekbom syndrome and delusional parasitosis, is a clinical disorder in which affected individuals have the fixed, false belief that they are infected with parasites or other living organisms. It is classified as a delusional disorder, somatic type in the *DSM-5*.[1] This condition is also encountered by dermatologists.[2] We present a case of delusional infestation in an individual infected with the human immunodeficiency virus (HIV).

Case report. Mr A, a 55-year-old, African-American man with a past medical history of HIV and syphilis, was admitted to the hospital for altered mental status. He denied having a past history of mental illness, and his only complaints were poor sleep and pruritus from a perceived infection. The patient reported a recent history of eating a sandwich that was "laced with snake eggs or parasite larvae." He believed that an infection had been spreading or "metastasizing" throughout his body, leading to his current physical complaint of generalized pruritus. He continued to perseverate on the idea that an infection was responsible for the pruritus, as he reported tactile hallucinations of a "wormlike parasite crawling in my scrotum." He denied auditory or visual hallucinations. He also denied suicidal or homicidal ideation.

The patient's family members provided collateral information, sharing their concerns about the gradual worsening of Mr A's mental status within the past year. They noticed a recent change that includes confusion and psychosis. Neighbors also had complained to the family about Mr A's bizarre behavior, which included searching through neighbors' trash and recycling bins.

Results of the physical examination and subsequent medical workup were consistent for a patient with a past history of HIV and treated syphilis. Cerebrospinal fluid analysis and head imaging also ruled out infectious and other organic etiologies. Despite medical workup results within normal limits and constant reassurance, Mr A continued to perseverate on the idea that he was infected by a parasite. Conclusions from the mental status examination were normal with the exception of the reported tactile hallucinations of "a wormlike parasite crawling in my scrotum" expression of delusional content and perseveration of that delusional content. Mr A continued to deny visual or auditory hallucinations, and he did not appear to be responding to internal stimuli. The patient also reaffirmed he had no suicidal or homicidal ideation.

On a consistent basis, the patient continued to complain of tactile hallucinations in the scrotal area. He also reported difficulty with sleep in the hospital. After a discussion of psychotropic medications as a treatment option, Mr A agreed to a trial of quetiapine. The antipsychotic medication was titrated to 200 mg in the morning and 400 mg in the evening. At this dose, the patient denied experiencing tactile hallucinations. He appeared to be stable—less distressed and less concerned about his delusional content—no longer perseverating on the delusional content.

In this case of delusional infestation in an individual infected with HIV, we diagnosed the patient with *DSM-5* psychotic disorder due to another medical condition because the history of HIV preceded the history of delusional content. A review of medical literature[3] supports the notion that individuals infected with HIV are at increased risk of mental illness including psychotic disorders.

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,*Fifth Edition (*DSM-5*). Arlington, VA: American Psychiatric Association; 2013.
2. Szepietowski JC, Salomon J, Hrehorów E, et al. Delusional parasitosis in dermatological practice. *J Eur Acad Dermatol Venereol.* 2007;21(4):462–465.
3. Blank MB, Mandell DS, Aiken L, et al. Co-occurrence of HIV and serious mental illness among Medicaid recipients. *Psychiatr Serv.* 2002;53(7):868–873.

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