A Case of Delusional Parasitosis Treated in an Outpatient Setting Using the Collaborative Care Model

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Delusional parasitosis is a rare manifestation of delusional disorder, somatic type.[1] Delusional parasitosis is characterized by a fixed, false belief that one's body is infested with living organisms without objective evidence to support this.[2] Treatment typically occurs in an outpatient setting with low-dose antipsychotic medications and frequent, validating therapeutic interactions.[3] While such treatment for delusional parasitosis is well-documented in typical outpatient settings, there are currently no reports of this condition being treated using the collaborative care model (CoCM). We aim to present the case of a woman suffering from delusional parasitosis who was treated in a CoCM setting.

Case Report

Ms A is a 70-year-old woman with a past medical history of depression, alcohol use disorder in remission, diabetes, hypertension, hyperlipidemia, and obstructive sleep apnea. She had a longstanding history of depression, which was acutely exacerbated approximately 1 year prior to presentation when she began to believe that she had "mites" in her skin. She had been evaluated by 2 dermatologists, neither of whom found evidence of infestation. She noted that she would often pick mites out of her skin but that they would "dehydrate" quickly, and she could thus never bring them to an office visit for evaluation. At this time, the patient was being treated for depression by her primary care physician (PCP) with oral duloxetine 60 mg/d and bupropion 300 mg/d. Ms A's PCP referred her to the CoCM behavioral health team consisting of a licensed independent social worker, attending psychiatrist, and psychiatry fellow who collaborate with the patient's PCP, who continued to prescribe all medications. While the CoCM behavioral health team managed Ms A's behavioral health problems, regular collaborative discussions with the patient's PCP allowed management of these problems in the context of medical comorbidities.

The CoCM social worker initially assessed and subsequently communicated with the patient as needed and discussed the case with the psychiatrists and PCP monthly. The psychiatrists provided management recommendations to guide the PCP's prescribing. The CoCM psychiatry team initially recommended cross-titration off bupropion in favor of aripiprazole. This cross-titration was completed, with the patient remaining on oral aripiprazole 5 mg/d. At 1-month follow-up with the CoCM team, the patient reported having a more "positive attitude" regarding her symptoms. At 3-month follow-up, Ms A felt that her symptoms had remitted. As she met her care goal, Ms A's CoCM case was closed, and her PCP was encouraged to reconsult CoCM if needed.

Discussion

Delusional parasitosis is a condition that is often very distressing to patients and can be challenging to treat.[4] Treatment typically involves a combination of psychotropic medications and frequent, validating outpatient visits. This can sometimes present a challenge, as the fixed nature of the patient's delusions may invite confrontation to which the patient may not respond well, and some dermatologists and PCPs may not feel comfortable prescribing antipsychotic medications. While antipsychotic medications have been found to be effective in the treatment of delusional parasitosis,[5] a study estimated that only approximately 3% of dermatologists feel comfortable prescribing antipsychotic medications.[6] CoCM[7] utilizes systematic psychiatric assessment in primary care settings with a nonphysician care manager who can perform longitudinal monitoring, treatment interventions, and coordination of care. Additionally, a psychiatrist reviews all cases with a care manager to provide further recommendations. CoCM, while not a new intervention, has a great deal of evidence for the management of depression and anxiety but has not been as widely studied in other psychiatric conditions.[8]

Delusional parasitosis can be difficult to treat and is often treated in primary care, dermatology, or psychiatry outpatient settings. However, considering that patients in primary care or dermatology clinics may be hesitant to accept referral to an outpatient psychiatrist, collaborative interventions deliverable in primary care or dermatology settings could add value in the care of these patients. CoCM represents

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an opportunity for collaboration between disciplines in the treatment of delusional parasitosis.[9]

Conclusion

Delusional parasitosis is a disorder that can prove very difficult to treat and may best be treated using a multidisciplinary approach. The collaborative and multidisciplinary nature of CoCM may lend itself well to the care of patients with this disorder and should be considered as a potential innovative approach to its treatment. CoCM is also an opportunity to expand collaboration between psychiatry, dermatology, and primary care.

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REFERENCES

1. Schizophrenia Spectrum and Other Psychotic Disorders. In: *Diagnostic and Statistical Manual of Mental Disorders*. *DSM Library*. American Psychiatric Association Publishing; 2022.
2. Lynch PJ. Delusions of parasitosis. *Semin Dermatol*. 1993;12(1):39–45.
3. Ansari MN, Bragg BN. Delusions of Parasitosis. In: *StatPearls*. StatPearls Publishing; 2022. Accessed April 15, 2022. https://www.ncbi.nlm.nih.gov/books/NBK541021/
4. Campbell EH, Elston DM, Hawthorne JD, et al. Diagnosis and management of delusional parasitosis. *J Am Acad Dermatol*. 2019;80(5):1428–1434.
5. Freudenmann RW, Lepping P. Second-generation antipsychotics in primary and secondary delusional parasitosis: outcome and efficacy. *J Clin Psychopharmacol*. 2008;28(5):500–508.
6. Gee SN, Zakhary L, Keuthen N, et al. A survey assessment of the recognition and treatment of psychocutaneous disorders in the outpatient dermatology setting: how prepared are we? *J Am Acad Dermatol*. 2013;68(1):47–52.
7. Huffman JC, Niazi SK, Rundell JR, et al. Essential articles on collaborative care models for the treatment of psychiatric disorders in medical settings: a publication by the Academy of Psychosomatic Medicine Research and Evidence-Based Practice Committee. *Psychosomatics*. 2014;55(2):109–122.
8. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10:CD006525.
9. Starzyk T, Koo J. How to improve the interface between dermatology and psychiatry: a review and expert suggestion regarding the management of delusional patients. *Dermatol Online J*. 2021;27(10).