

CASE REPORT

Risperidone Long Acting Injection (RLAI) in Delusional Parasitosis

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Abstract

Delusional Parasitosis is a condition in which a person has a fixed belief of being infested with parasites or small living creatures although there is no medical evidence for this. Both typical and atypical antipsychotics have been used to treat this condition. Among atypical antipsychotics oral risperidone has the best evidence base but most of the patients with this condition are reluctant to take any oral psychotropic medication and it might become necessary to use depot antipsychotic preparations. There is no evidence about the use of risperidone long acting injection (RLAI) in this condition. We present a case report which shows risperidone long acting injection can be very beneficial in this condition but further research is needed to support our findings (German J Psychiatry 2009; 12: 35-37).

Keywords: delusional parasitosis, antipsychotics, risperidone, risperidone depot, risperidone long acting injections

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Introduction

Delusional parasitosis is a condition in which a person has a fixed belief of being infested with parasites or small living creatures although there is no medical evidence for this (Arnold, 2000; Freudenmann, 2002). This condition mostly occurs in older women (Reilly & Batchelor, 1986). Sufferers usually complain about itching and would describe feelings of burrowing and biting due to the presence of animals in or under the skin. It can occur as a delusional disorder, meeting ICD-10 criteria for persistent delusional disorder (WHO, 1993) and DSM-IV-TR criteria for delusional disorder, somatic type (APA, 2000). Because of their somatic concept of illness these patients usually present to general practitioners and dermatologists first, who refer them to psychiatric services. The psychiatric referral is usually objected by these patients (Lyell, 1983) and therefore the management of these patients is a great challenge and most of them are reluctant to engage in a meaningful therapeutic relationship. Most of

these patients lack insight into their condition and might refuse taking any oral medication. It might become necessary to treat these patients with injectable preparations especially if there are concerns about the risks. Many patients lose faith in professional medicine and resort to dangerous self-therapies such as excessive skin cleaning by using chemicals or pesticides (Freudenmann, 2002). On occasions health authorities have been called to disinfect houses (Edwards, 1977). Different antipsychotics including old generation depot preparations have been used to treat delusional parasitosis but there is no evidence about the use of risperidone long acting injections (RLAI) so far (Lepping et al, 2007). We present a case report in which risperidone long acting injection was used with a successful outcome.

Case Report

The patient is a 58 years old lady who is separated, unemployed, living with her two sons. She presented to our services with features of persistent delusional disorder (Delusional Parasitosis). She has been known to psychiatric services since the age of 18 years with history of recurrent depressive illness and has been on citalopram 20 mg for a long time. Her last depressive episode was about 2 years back. There is no family history of any significant mental health problems.

She presented with a belief that she and her house are infested with fleas, bugs and tics. She was evaluated by her general practitioner (GP) and all the organic causes including dermatological were ruled out. She felt that there are billions and billions of fleas jumping out of her hair like the rain drops and falling on the floor and in her food. She was drinking from a plastic bottle to prevent the fleas going into her drink. She attempted to use a vacuum cleaner on her hair to get rid of these fleas and was using flea creams and sprays but felt that fleas won't die. She had even called the pest control twice and had treated her dogs for the fleas.

She believed that she caught these fleas from one of her son's friend's dog. There were no other major triggers identified. She sometimes felt that fleas are beneath her skin and sometimes felt that they are burrowing into her skin. She felt that these fleas could not be seen by the naked eye and a magnifying glass was required to see them.

When challenged or asked about a plausible explanation for this she would become irritable. On mental state examination there were no depressive or any other psychotic features identified. There was no evidence of any features of dementia; her cognition was intact and her long and short term memory was normal. About five months back, there was history of amphetamine use for few months. There was no history of any other illicit drug use like cocaine, heroin, cannabis etc.

She was started on risperidone which was gradually increased to 3 mg/day but she was non-compliant with the medication. She completely lacked insight into her condition and refused to take medication and cooperate with clinicians. Her mental state gradually deteriorated in few months and her delusions became more intense. She also started taking part in risky behaviours; she started using pesticides and insecticides to get rid of these fleas.

Because of the ongoing risk to her life and lack of insight, she was detained under mental health act and admitted to an acute psychiatric ward. A biochemistry, toxicology and haematology screen was done. Most of the investigations were normal except she was a slightly anaemic with Hb of 10.4 and was positive for morphine and codeine on toxicology screen (She was prescribed dihydrocodeine).

Whilst inpatients she was initially started on quetiapine for some time but again she refused to take it. It was then decided to start her on risperidone tablets again with an aim to change it to risperidone long acting injection considering the issues of non-compliance. The oral dose of risperidone was

increased to about 4mg/day but she continued to be reluctant to take it. She was started on risperidone long acting injection, 25 mg IM every two weekly. She started showing some improvement in her symptoms and she was discharged on risperidone long acting injection, 37.5 mg IM every two weekly. After few weeks she gained some insight and accepted that she suffers from a mental illness. She requested to stop her injections and was quite happy to take oral risperidone. She remained compliant on the medication with input from a community psychiatric nurse. She was maintained on risperidone 5 mg/day. She was followed up on regular basis in the out patients clinic and after a few months she showed a significant improvement in her symptoms. Although she has not achieved full remission yet but she has gained a significant insight into her illness. She does not engage in any activities to get rid of the fleas and now believes that these could be just her imaginations. She is not distressed any more and has started eating and drinking normally. Her overall socio-occupational functioning has improved and she has started a new relationship recently.

Discussion

The prognosis of delusional parasitosis was generally considered to be poor in the past (Edwards, 1977) but as discussed earlier antipsychotics have proven to be beneficial in this condition. Unfortunately there are no controlled trials available for the use of antipsychotics in this condition and most of the evidence is from the case reports. Among typical antipsychotics many sources recommended the use of the pimozide in delusional parasitosis (Driscall et al, 1993; van Vloten, 2003), but it has got high risk of extrapyramidal symptoms, longer QTc interval and drug-drug interaction (FDA, 1996; NICE, 2002; Benkert and Hippus, 2005). The evidence from the case reports have indicated the beneficial effects of atypical antipsychotics like risperidone (Gallucci and Beard, 1995; Freyne et al, 1999; Moretti and Varga, 2000), quetiapine (Kim et al, 2003), olanzapine (Le and Gonski, 2003) and amisulpride (Leeping et al, 2005). Risperidone has a better data base than other atypicals and there is some evidence that risperidone has helped to achieve full remission in few cases.

There is lack of evidence about the use of risperidone long acting injection in this condition. It is the only atypical antipsychotic available in a long acting or depot formulation. Currently, risperidone long acting injection is available in strengths of 25 mg, 37.5 mg and 50 mg injections. After receiving the first injection it takes 3 weeks before the medicine starts to be released, thus, requiring a patient to continue taking the oral risperidone for the first 6-8 weeks.

The above case report clearly shows how the patients with this condition can lack insight and refuse to engage in a meaningful therapeutic relationship. It also shows that using risperidone long acting injection in these patients can be significantly beneficial in improving their symptoms. Risperidone long acting injection could also be used when there are significant risk issues e.g., in patients using pesticides and chemicals. It could be continued till patients achieve remis-

sion or could be changed to oral risperidone once patient regains the insight and start accepting the oral medication. We therefore suggest that risperidone long acting injection can prove very beneficial in delusional parasitosis but more evidence is required to support this.

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