Not Just A Delusion: Practical Tips for Managing Psychodermatology Patients

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DISCLOSURE OF RELEVANT RELATIONSHIPS

No Financial Interests
DISCLOSURE OF RELEVANT RELATIONSHIPS

Married to the field: Michelle Magid, MD (Psychiatrist)

GRADUATE MEDICAL EDUCATION
Objectives

- Perform the appropriate evaluation and testing on a patient that "sees bugs."

- Initiate management for a patient that "sees bugs."
First, a few cases…

Case 1: “I have bugs on my skin”

- 65 yo male complains of bugs on his skin. He has found examples of them and brought them in for you.

- He knows he contracted them from a dirty barn. He needs you to help him get them out.

- On exam, he speaks quickly, and cannot answer questions about anything other than his bugs. You see senile purpura and SKs.
Case 2: “I have something in my skin”

- 45 yo female, otherwise healthy, presents with concerns of bugs.
- She thinks she has some biting sensations, and definitely feels crawling.
- She brought in a sample in her mom’s pillbox.
- On exam, she has a mild dermatitis on the forearms and upper back.
And it affects my nails
Case 3: “I have threads in my skin”

• 60 yo female presents concerned she has threads growing out of her skin

• She has been dealing with chronic back pain issues, sleeping poorly, and feels fatigued.

• Her review of systems is pan-positive.

• Exam reveals multiple excoriations on the face, arms, and chest.
What kind of patients come in with ‘something in their skin’?

Primary Dermatologic problem
Primary Medical problem (causing psych)
Primary Psychiatric Problem
‘Something in my skin’: Primary Dermatologic

- Immunobullous disease
- Infection (molluscum, scabies, lice, tinea, folliculitis)
- Dermatitis (irritant, contact)

Patients with mental health issues can have skin diseases, too!

- Schizophrenia
- Bipolar Disorder
- Drug Use/ Withdrawal
- Sleep Disorders

‘Something in my skin’: Primary Medical

(medical causes of psychiatric disease)

- Delirium: Polypharmacy: anticholinergic effects
  – (elderly, decreased hepatic metabolism)
    • H1 and H2 blockers
    • P.O. steroids
    • Rare (I have not seen): Loop diuretics, digoxin, and Ca-channel blockers, CsA, azothioprine, amox, clinda, vanc;

- Delirium: Metabolic (hypoglycemia, UTI, etc)
‘Something in my skin’: Primary Medical (medical causes of psychiatric disease)

- Dementia (Parkinsons, Picks’ Dz, Alzheimers)
  - Dopaminergic drugs
- Skin picking often triggered by ADHD meds
- Opioids may hit itch receptors

‘Something in my skin’: Primary Medical (exacerbates medical/psychiatric disease)

- Liver/Kidney/Thyroid problems
- Anemia, Polycythemia
- ? Vitamin D deficiency
- HIV
‘Something in my skin’:
Primary Medical

Neurologic:
• Diabetic Neuropathy
• Pinched Nerve
• Notalgia Paresthetica/ Trigeminal Neuralgia
• Pruritis Ani

‘Something in my skin’:
Primary Psychiatric

Rule out all derm/medical/neurologic causes
‘Something in my skin’: Primary Psychiatric

• **Pickers/Pokers/Pullers**
  – They don’t really worry about infestation
  – They may feel a need to ‘get the hair out’
  – Skin picking, Acne excoriee, Trichotilomania

• **The Spectrum of Delusions of Parasitosis**

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Morgellons Disease
Morgellons Disease

• Term coined by Mary Leitao, a woman who found ‘fibers’ on her son’s skin, found people with similar symptoms, and formed the Morgellons Disease Foundation in 2002.
• Refers to a paper written by Sir Thomas Browne in 1674
  – Refers to children/patients called the “Morgellons”
  – “mouscouloun” meaning ‘hook on a spindle’

“fiber disease”

• >14,000 families registered
• “morgies”
Morgellons Disease

“The New Morgellons Order”

aka

“The Charles E. Holman Foundation”

• Case Definition
  – “Fibers” in and on skin
  – Skin lesions, both spontaneously appearing and self-generated, with intense itching.
  – Crawling sensations
  – Fatigue
  – Cognitive difficulties, "brain fog".
  – Behavioral effects
Morgellons Disease

Treatment by “Morgellons” specialists
- No standardized protocol
- Treat underlying tick-borne illness (Lyme dz, Borreliosis)
- Concomitant treatment with antiparasitics and antibiotics

I HAVE NEVER USED THESE PROTOCOLS ON MY PATIENTS

Morgellons Disease: The CDC Review

- “Clinical, Epidemiologic, Histopathologic and Molecular Features of an Unexplained Dermopathy”
- Kaiser Permanente group

Morgellons Disease: The CDC Review

• Conclusion:
  – No pattern of clinical or epidemiologic abnormality that suggested any specific infectious etiology
  – Not able to conclude whether this unexplained dermopathy represents a new condition… or wider recognition of an existing condition such as delusional infestation, with which it shares a number of clinical and epidemiologic features

Morgellons Disease: a rapport-enhancing term?

• Cynical physicians should have some caution in endorsing this term
  – Desperate self-medicating patients
  – Morgie websites specifically mention that antipsychotics are not used to treat Morgellons Disease
  – Morgie websites advise patients to avoid telling their physicians about their symptoms and one hints at litigation for being diagnosed with DOP
  – I see a difference between these patients and classic “DOP® patients
The Spectrum of Delusional Ideation

Skin Picking (dermatotillomania)

- No longer considered impulse-control (like kleptomania), but on the obsessive-compulsive spectrum.
Skin Picking (dermatotillomania)

• Characterized by:
  – Anxiety, tension, boredom (not a true ‘obsessional’ thought)
  – Repetitive behaviors leading to relief of bad feelings (vs impulse disorders lead to good feelings)
• Most patients have insight

Skin Picking (dermatotillomania)

• Trigger
  – An already present benign lesion (e.g. ingrown hair, acne)
  – “I may have scratched at it a little.”
• Most common area
  ▪ The face
• Mean time spent picking
  ▪ 107 minutes
Trichotillomania

- OCD (like skin picking)
- Patients have insight! So open discussion (once patient admits to the problem) is okay.

Overvalued idea

- a solitary unfounded belief
- the patient feels crawling, stinging, or biting, is concerned this indicates an infestation, but can be easily reassured otherwise by the dermatologist.
- may be those most likely to ‘jump to conclusions’
  – (documentation of routine and intermittent delusional ideations in 10-15% of the general population)
Somatic preoccupation

• fixated on a subjective cutaneous symptom(s)
• often have a somatic symptom disorder
  – Physical complaints in several body systems (e.g. rheum, GI, urinary, skin) that suggest a medical condition but:
    • cannot be explained by a known general condition
    • the physical complaints result in social or occupational impairment in excess of what would be expected from medical investigation

Somatic preoccupation

• may suffer from depression, post-traumatic stress disorder, or feelings of guilt.
  – may have experienced a recent exacerbation temporally related to psychological stressors.

• Have some insight (“I know this sounds crazy but…”)
Delusional state

- A false belief is held with immutable conviction despite all efforts by the dermatologist to persuade otherwise.
- Logical dissonance regarding this infestation, but functioning/behavior is not markedly impaired

Impaired insight/ logical dissonance:
- Pt may have attempted inappropriate treatments, such as gasoline, Borax, or burning themselves (with fire or chemicals)
- Pt’s need for validation may begin to override the desire for symptomatic relief
- Many have no skin findings. Watch for 2° causes
Terminal delusional state

- the most rigid and severe delusional patient.
- **validation** is the primary motivation for seeking care, with treatment of symptoms being secondary.
- delusions tend to be elaborate with bizarre content and vivid details.
- almost always had for many years.

The Spectrum of Delusional Ideation
### The Spectrum of Delusional Ideation

<table>
<thead>
<tr>
<th>Delusional Ideation Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overvalued Idea</td>
<td>Insight into uncertainty of infestation</td>
</tr>
<tr>
<td>Somatic Preoccupation</td>
<td>Relief from symptoms is more important than validation of infestation</td>
</tr>
<tr>
<td>Delusional State</td>
<td>Lack of insight, ideation is fixed</td>
</tr>
<tr>
<td>Terminal Delusional State</td>
<td>Validation of infestation becomes dominant focus</td>
</tr>
</tbody>
</table>

**Skin Pickers**

20% 10% 40% 30%

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**How can I tell the difference?**
One clue… look at the chief complaint

If a patient complained of:

- **INFECTION** they had a 52% chance of DOP 33% Somatic Preocc.
- **FIBERS/SPECKS** they had a 22% chance of DOP 67% Somatic Preocc.

Ask the question: “What do you think is causing the problem?”

- “There is something bothering my skin”
- “I don’t know, but it feels like bugs crawling.”
- “There are insects in my skin. Get rid of the insects and I’ll be fine”

Skin Pickers
ROS: only looking at 24 items assessing 'symptoms'
Clues to Somatic Preoccupation

- This person has a lot of physical complaints!
- Suffering out of proportion to their clinical symptoms

Modified MINI Screen

- Depression
- Mania
- Anxiety
- OCD
- PTSD
- Psychosis

Legend:
- Green: DOP and Schizo
- Purple: Medical/ nothing
- Orange: Somatoform
Don’t miss an actual Psychotic Disorder

- Psychiatric illness in which the predominant symptomatology is psychosis
  - Delusions
  - Hallucinations
  - disorganized speech
  - disorganized behavior

- Schizophrenia

- Bipolar Disorder can mimic Psychotic Disorder
• Questions?

Approach to these patients: the first (diagnostic) visit

Setting expectations
Physical Exam while taking HPI
Clinical and Laboratory testing
Setting Expectations

If they are sad/ upset:
   Empathize with their problems
   “You are not alone”
   “You are clearly suffering, this disease is causing you tremendous pain”

If they are angry:
   Point this out to them
   “I didn’t do this to you”

If they are defensive:
   Point out that you are a ‘medical doctor’ and will look at all causes of disease

As Dr. Koo has said “they are seeing you to be their Dermatologist, and Dermatologists are busy!”
Setting Expectations

Just like any complicated medical problem
• Multiple visits will be required
• Review previous medical and psychiatric records
• Review laboratory and biopsy reports
• We will rule out ‘easily treatable’ problems
• If they have a ‘medical problem’ they will require trial-and-error treatments

• Long visits are required

Physician expectations: these are HARD patients!

“Every patient deserves one, and only one, good work-up”

• Head-to-toe exam, no matter what!
  – May include weight, vitals
  – Look for treatable skin disease:
    • Lice, MC, Lichen Planus, Folliculitis, Steroid Atrophy, Melanoma!
“Every patient deserves one, and only one, good work-up”

• Look at their ‘bugs’
  – Ants, bed bugs, scabs
  – If you submit these materials, know your pathologist/microbiologist:

  “Please comment on the presence of human pathogens”
  or have them write
  “no human parasites identified”

“Every patient deserves one, and only one, good work-up”

First- Rule out organic causes
• Thorough medication history
  – OTC meds, Rx meds, herbs, “foreign” meds
  – Opioids, stimulants or other drugs of abuse
“Everybody deserves one, **and only one**, good work-up”

First- Rule out organic causes
- Detailed review of systems
- Let them do the work!
  - Printed ROS
  - **Modified MINI Screen (MMS)**, PHQ 15, or similar brief psychiatric questionnaire for ‘difficult skin problems’
  - HADS, SkinDex or other Quality of life screens

“Everybody deserves one, **and only one**, good work-up”

- Determine character of symptoms
  - Crawling/stinging/burning
  - Dermatomal?
Clues to Skin Picking

Clues to Skin Picking

Clues to Skin Picking
Clues to Trichotillomania

- Hair is present in difficult to reach areas (e.g., occiput)
- Hair is present in sensitive areas (sideburns)
- Areas often affected: scalp, eyebrows, pubic area, underarms, beard
- Hair is in all stages of growth
- Affected area may have an unusual shape or change from visit to visit

Approach to these patients: the first (diagnostic) visit

- Ask them to stop all non-essential medications, enlist help of significant others
- No treatment unless you know a specific cause
- Quick follow-up, longer appointment
“Every patient deserves one, **and only one**, good work-up”

Laboratory Testing may need to be the second visit

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“Everybody deserves one, **and only one**, good work-up”

Laboratory Testing (reimbursement tricky)
- CBC, electrolytes, LFTs, Thyroid cascade (R20.9: Skin sensation disturbance)
- Ferritin, B12, Folate (R53.81: Other malaise and fatigue)
- U/A (R53.81: Other malaise and fatigue)
- HIV, Hep C (R53.81: Other malaise and fatigue)
- Urine drug screen “to look for toxins” (R41.82: Other alteration of consciousness)
- ? Vitamin D (M89.8X9: bone pain)
“Everybody deserves one, **and only one**, good work-up”

– Ask for a ‘fresh’ lesion or ‘new’ samples, or cover an area for them

Approach to these patients: the f/u (treatment) visit
Approach to these patients: the f/u (treatment) visit

Treat the underlying cause (if you are that lucky!)

Biopsy a ‘fresh’ lesion if one exists (consider DIF).

Approach to these patients: the f/u (treatment) visit

If no disease can be found:

Treatment of concomitant staph superinfection
   Bleach Baths

Treatment of prurigo nodules
   low dose intralesional triamcinolone +/- lidocaine
   phototherapy
   healing emulsion
   UnnaBoot
Approach to these patients: the f/u (treatment) visit
If no disease can be found:

Treatment of muscle dysesthesias, twitches
onabotulinumtoxin A …?

Ask the question: “What do you think is causing the problem?”

“There is something bothering my skin”

“I don’t know, but it feels like bugs crawling.”

“There are insects in my skin. Get rid of the insects and I’ll be fine”
Approach treating the patient with Insight (Trichotillomania/Picking)

• Normalize the situation
  – “Many people in situations of boredom or stress develop a habit. Some people smoke, others bite their nails…and others pull their hair. Does this sound like you?”

Approach treating the patient with Insight (Trichotillomania/Picking)

• Once a “confession” is made, continue to normalize and work on motivational interviewing to get the patient to see a psychologist
  – “I see this all the time. This is quite a common habit.”
  – “How has this affected your life?”

• TTM- Reassure the patient that normal hair regrowth is usually possible if hair is left alone
Trichotillomania/ Picking Treatment

• Treat underlying itch/ lesions
  – Unna Boot, IL Kenalog
  – Treat acne/folliculitis/eczema, shave a patch of hair

• Cognitive Behavioral Therapy
  – Replacing pulling behaviors with a competing enjoyable activity
  – Journaling to determine situations that trigger pulling behaviors
  – Removing triggers (e.g. mirrors, staying away from places that trigger the behavior, etc…)

• Medication Management
Trichotillomania/ Picking Treatment

- Pharmacotherapy
  - TCA
  - SSRIs (may need higher doses)

<table>
<thead>
<tr>
<th></th>
<th>Efficacy</th>
<th>Tolerability</th>
<th>Sexual Side Effects</th>
<th>Weight Gain</th>
<th>Starting Dose</th>
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</thead>
<tbody>
<tr>
<td>Clomipramine</td>
<td>+++</td>
<td>+</td>
<td>++</td>
<td>+++</td>
<td>25 mg qhs</td>
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<tr>
<td>Fluvoxamine</td>
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<td>-</td>
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<td>Fluoxetine</td>
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<td>-</td>
<td>10-20 mg qday</td>
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<tr>
<td>Citalopram</td>
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<td>++</td>
<td>-</td>
<td>10-20 mg qday</td>
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<tr>
<td>Sertraline</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>-</td>
<td>25 mg qday</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>10-20 mg qday</td>
</tr>
<tr>
<td>Behavioral Therapy</td>
<td>++</td>
<td>+++</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring: No routine labs necessary.
Clomipramine: overdose can be lethal
Black Box warning: People under age 24 may rarely have increased agitation and suicidal thoughts when first starting the medication
Overvalued idea

- Reassure the patient!
- Follow-up to ensure the problem is gone

“There is something bothering my skin”
Somatic preoccupation

- Pt may be easily mistaken to be delusional, particularly if defensive or antagonistic.
- Make the patient feel respected, develop a trusting therapeutic rapport with the patient.
- Then you can diplomatically challenge the patient’s beliefs.
- Articulate that relief from symptoms is more important than affirmation of infestation.

Pharmacotherapy
- “I have found that SSRIs work for your problem. They reduce the sensation of itching/pain.”
- “This medication will help you function better with your condition.”

Psychotherapy
- A gradual shift in focus from somatic preoccupation to an emphasis on personal and interpersonal problems.
Somatoform Goal

- Prevent the adoption of the sick role
  (unemployment, personality disorder, potential for compensation associated with poorer prognosis)
- Try to reduce the patient’s suffering in order to **improve** his/her quality of life.

### Cutaneous Sensory Disorder Treatment

<table>
<thead>
<tr>
<th>Treatment of Anxiety/Depression with Somatoform</th>
<th>Efficacy</th>
<th>Tolerability</th>
<th>Sexual Side Effects</th>
<th>Weight Gain</th>
<th>Starting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duloxetine</td>
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<td>20-30 mg qday</td>
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<tr>
<td>Fluoxetine</td>
<td>++</td>
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<td>++</td>
<td>-</td>
<td>10-20 mg qday</td>
</tr>
<tr>
<td>Citalopram</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>-</td>
<td>10-20 mg qday</td>
</tr>
<tr>
<td>Sertraline</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>-</td>
<td>25 mg qday</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>+++</td>
<td>+++</td>
<td>-</td>
<td>-</td>
<td>(use if psychological component to illness)</td>
</tr>
</tbody>
</table>

- absent + weak  ++ moderate  +++ strong

**Monitoring:** No routine labs necessary.

**Black Box warning:** People under age 24 may rarely have increased agitation and suicidal thoughts when first starting the medication
Delusional state

- Lack insight.
- Believe that bugs are causing the problem.
- You cannot convince them otherwise.

Delusional state

- Validate suffering
  - “I believe your distress is real and you are suffering.”

- Empathize
  - “I wish I had something to offer you to ‘fix’ the problem, but I don’t.”

- Reassurance
  - “You have no signs of a contagious disease.”
  - “I have had several patients with similar presentations do well on treatment.”
“There are insects in my skin. Get rid of the insects and I’ll be fine”

Delusional state

- diplomatically broach the topic of antipsychotic treatment
  - “We’re not sure why, but neuroleptics work for your problem
  - Adjust the ‘mind-body connection’
  - Reduce the sensation of ‘normal skin flora’
  - Maybe it attacks the bugs’ nerve
  - We use medications for other uses than their FDA approved indications
  - “My patients tell me their symptoms go away. I don’t know why.”

### Treatment for Delusions of Parasitosis

<table>
<thead>
<tr>
<th>Anti-sement</th>
<th>Efficacy</th>
<th>Tolerability</th>
<th>EPS</th>
<th>Weight Gain</th>
<th>Sedation</th>
<th>Ach</th>
<th>Starting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
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<td>++</td>
<td>++</td>
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<td>-</td>
<td>1 mg BID</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>5 mg qhs</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>++</td>
<td>+++</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>-</td>
<td>40 mg BID</td>
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<tr>
<td>Aripiprazole</td>
<td>++</td>
<td>+++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>5 mg qhs</td>
</tr>
<tr>
<td>Pimozide</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>++</td>
<td>-</td>
<td>1 mg BID</td>
</tr>
</tbody>
</table>

- absent  - weak  ++ moderate  +++ strong

EPS- Extrapyramidal Syndrome  Ach-Anticholinergic properties

Monitor: Lipids, glucose, weight q4-6 months.

Pimozide should not be used in patients with heart disease, get a baseline EKG

Ziprasidone should get a baseline EKG

Risperidone: can increase prolactin levels

Consider using concurrent treatment with anticholinergic medication (e.g. Cogentin 1 BID, or diphenhydramine 25 qhs, for the first 4 weeks) to decrease chances of EPS
Delusions of Parasitosis:  
Treatment

• Psychotherapy  
  – No proven efficacy  
  – Referral to Psychologist/Psychiatrist (good luck!)

Delusions of Parasitosis:  
Goal

– Try to reduce the patient’s suffering in order to improve his/her quality of life.  
– You will not rid the patient of his/her bugs.  
  You will help them function better with it.  
– Sensations resolve first; the belief in bugs may resolve much later (or never)  
– poor prognosis unless caught early
Terminal delusional state

• the most rigid and severe delusional patient.
• will decline most interventions as it does not “prove the bugs are real”.
• may offer general dermatological care
• may be impossible to motivate for treatment, may need to terminate relationship

One last warning…
One last warning…

• Risk Management
  – Patient threats
  – Formal complaints about the physician
  – Request for medical records via subpoena

One last warning…

• Of all patients seen in my regular derm practice, Risk Management has been called..
  – 3/7574 cases
  – 0.04% of the time
One last warning…

- Of all patients seen in my regular derm practice, Risk Management has been called:
  - 3/7574 cases
  - 0.04% of the time
- In the patients reviewed in this study, risk management was called:
  - 6/47 cases
  - 13% of the time (300 fold increase!)
65 yo male complains of bugs on his skin. He has found examples of them and brought them in for you. He knows he contracted them from a dirty barn. He needs you to help him get them out. On exam, he speaks quickly, and cannot answer questions about anything other than his bugs. You see senile purpura and SKs.
How we approached this patient with bizarre delusions

• History reveals a remote history of unusual behaviors but never enough to affect his life.
• In the past 5 years, he has been diagnosed with Parkinsons Disease. The patient’s symptoms seem to have begun 2 years later.

• Discussion with the neurologist, symptoms worsened as carbidopa/levodopa increased

• Medications adjusted, with some reduction of his symptoms but they still persist
Case 2: “I have something in my skin”

- 45 yo female, otherwise healthy, presents with concerns of bugs.
- She thinks she has some biting sensations, and definitely feels crawling.
- She brought in a sample in her mom’s pillbox.
- On exam, she has a mild dermatitis on the forearms and upper back.
And it affects my nails
How we approached this anxious patient

• Detailed evaluation of the skin

• Met with patient’s family and examined their skin as well

• She had been applying hydrogen peroxide to her skin and nails repeatedly- asked her to stop

How we approached this anxious patient

• Sent a specimen to our pathologist who confirmed “no presence of human pathogens”

• Reassured patient and family they were not contagious
How we approached this anxious patient

• Learned she had a history of anxiety and OCD.

• She called twice the next week, worried that they finally found something. We asked her to see us again the following week.

How we approached this anxious patient

• After repeat exam, I suggested this was impacting her quality of life.

• Started citalopram. Spoke with her therapist so they could work on this together.

• Saw her in 3 weeks, then again in 2 months.
How we approached this anxious patient

- She was not sure it was helping...

- We see her q6mo. She still expresses some concern about her sensations but family says she is much better.

Case 3: “I have threads in my skin”

- 60 yo female presents concerned she has Morgellons Disease.
- She has been dealing with chronic back pain issues, sleeping poorly, and feels fatigued.
- Her review of systems is pan-positive.
- Exam reveals multiple excoriations on the face, arms, and chest.
Case 3: “I have threads in my skin”

• 60 yo female presents concerned she has threads growing out of her skin

• She has been dealing with chronic back pain issues, sleeping poorly, and feels fatigued.

• Her review of systems is pan-positive.

• Exam reveals multiple excoriations on the face, arms, and chest.
How we approached this patient concerned about ‘Morgellons’

• History of severe PTSD, anxiety, and depression, but stopped meds a few years ago due to cost

• Due to back pain was on oxycodone

How we approached this patient concerned about ‘Morgellons’

• We suggested she talk to her psychiatrist about restarting her aripiprazole

• Spoke to pain docs about tapering off oxycodone

• To help the wounds heal, we applied a zinc wrap to the arms, one at a time
How we approached this patient concerned about ‘Morgellons’

• She remains on aripiprazole and no longer has concerns about bugs

• She was able to hold her granddaughter for the first time
Conclusions

• Treatment of OCD disorders- have insight- SSRIs and Behavioral Therapy

• Treatment of Somatoform disorders- some insight- SSRIs and Psychotherapy

• Patients without insight- don’t confront

• Treatment of psychotic disorders- antipsychotics and try to refer when possible.

For More Information…

M Magid, J Fridlington, J Reichenberg. Management of Psychodermatologic Disorders. US Dermatology. Volume 3, Published online in 2008 by Touch Briefings

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