Case Report

Ekbom’s syndrome and Renal Dialysis: case report

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ABSTRACT

A case is described which presented with feeling of insects crawling on her body and had renal failure. (Rawal Med J 2005;30:94-95).

Key words: Ekbom’s syndrome, Delusions of infestation, Psychosis

INTRODUCTION

The Ekbom’s syndrome, also known as delirium of parasitic infestation, acarophobia, delusional parasitosis, psychogenic parasitosis, is a disease of rare occurrence. It is a disorder in which the patient believes that he/she is infected by a parasite. Generally, it is characterised by the firm conviction of the patients to be infected by worms that come out of the skin, usually from the scalp or even from the mouth, from the eyes or from the genital region.Epidemiologic, nosologic, psychopathologic and therapeutic data can barely be interpreted, as Ekbom’s syndrome has mostly been described in either isolated cases or small cohorts.

Ekbom’s syndrome is a chronic disorder that may occur at any age but is more commonly in the elderly, particularly in females. International classifications have included this syndrome in non-schizophrenic delusions. However, it has also been reported in schizophrenic, affective disorders and organic or induced psychosis. Some cases are associated with organic diseases such as hyperthyroidism, diabetes, cortical lesion and intoxication by medicines. To our knowledge the association between Ekbom’s syndrome with renal dialysis has not been described in literature. We report the case of a 67 year old woman with Ekbom’s syndrome associated with renal dialysis.

CASE REPORT

A 67 year old woman presented with a history of diabetes for the last 15 years along with history of hypertension for the last 5 years. Her coronary artery bypass grafting was done in 1998 and a permanent pace maker was implanted in 1999. She had her
thyroidectomy done 20 years back. She was married and a housewife with four children.

She first presented at Shifa International Hospital 4 years ago with history of increasing abdominal distention along with right hypochondrical pain and dyspnea on exertion. She had grade 2 pitting edema of both feet. Her chest X-Ray showed cardiomegaly. TSH levels were found to be 6.86. She was admitted with a diagnosis of chronic renal failure and congestive heart failure. On echocardiography, she was found to have normal left ventricular function. The patient had her intravenous fistula in May 2002 for renal dialysis.

She visited this hospital a year ago for routine check up and her serum calcium level was found to be high (15mg/dl). She was admitted for appropriate treatment. She was placed on twice weekly renal dialysis and 2 months later she developed chest pain radiating to left arm with nausea and vomiting followed by incoherent speech while she was undergoing renal dialysis. Four months later she developed infection at the site of fistula and was found anemic. Her serum creatinine was 4.2 and total leukocyte count was 9600/cmm. Her ultrasound examination showed small sized ecgogenic kidneys with corticomedullary disease suggestive of chronic renal parenchymal disease.

She presented at the psychiatric clinic in May 2005 on an out patient basis with the complaints of insects crawling on both of her legs and arms for the last 6 months. According to the patient, they were biting her and were white and brown in color. She described having disturbed sleep and had many episodes of waking up in the middle of the night screaming and shouting with complaints of burning and crawling sensations. She was convinced that the insects had invaded her home as well as Shifa International Hospital. Her consistent complaints invariably led to management difficulties during dialysis in the Nephrology Clinic. Frequent attempts to satisfy her that such infestation did not exist in reality failed to impress her abnormal belief in any way. She was diagnosed as Ekbom’s syndrome and described as presenting with mono symptomatic hypochondrical delusion. She was prescribed Olanzia 5mg daily orally. She was followed up at the psychiatric clinic on weekly basis. She showed a very good response to the treatment and had no complaints regarding insects crawling on her body after the third visit. She admitted feeling better than before, however, she remained concerned about the insects.

DISCUSSION

Although the earliest well documented case appears to be that described by Thibierge and he applied the term “Acarophobia”, Ekbom was the first to clearly differentiate the syndrome from entomophobia and his name is often used eponymously therewith. The most important diagnostic consideration is an awareness of the fact that the patients with Ekbom’s syndrome experience the state of being infested. This is fundamentally different from having a fear of becoming infested, which falls into the category of entomophobia. This distinction has not been made clearly in the literature and is often a source of confusion between phobia and delusions. The phobia entails a better prognosis, as reality testing remains unimpaired.
There is an ongoing debate as to whether dermatologists or psychiatrists should treat patients with Ekbom’s syndrome. Dermatologists often argue that although psychiatrists are better qualified to deal with the delusions, the nature of the patients is such that they are likely to be lost to treatment should a psychiatrist to be mentioned. It is, therefore, better for the dermatologist to maintain treatment on typical or atypical antipsychotics for example, than it is for the patient not to be treated at all.

Given the complete independence of the respective specialties we conclude in favour of a genuine cooperative association between two independent specialists for an ideal treatment of this rather rare disorder.

REFERENCES