SKIN

SHORT COMMUNICATION

When Should Dermatologists Refer Delusions of Parasitosis Patients to Psychiatry: An Expert Recommendation

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Many patients with delusions of parasitosis (DoP) prefer to be managed by dermatologists instead of mental health professionals (MHPs). Some DoP patients can successfully be managed by dermatologists; however, others should be referred to MHPs, even if the dermatologist is experienced in the use of anti-psychotics. Herein, we address the question of how dermatologists can make the decision regarding whether or not to refer DoP patients to MHPs. We propose three ways to make this determination.

First, the dermatologist should determine whether the patient's erroneous belief regarding a parasitic infestation is primary or secondary. A primary delusion is one that has occurred spontaneously and cannot be explained by the presence of another disorder; meanwhile, a secondary delusion occurs because of another condition such as drug abuse or schizophrenia. Patients with secondary delusions should be referred to MHPs who have the resources to address the underlying cause of the delusion, including inpatient or outpatient psychiatric care and drug rehabilitation.

Second, the dermatologist should determine the content of the delusion; delusions can range from realistic and encapsulated to bizarre and global. In contrast to schizophrenia or other diseases with more global psychiatric dysfunction, DoP is categorized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition as a delusional disorder where the patient may exhibit no other pathology outside of the chief complaint of parasites.[1] Primary DoP can be considered encapsulated when the patient would be indistinguishable from a person without pathology if the topic of parasites was not discussed. Moreover, in primary DoP, the content of the delusion may vary. For example, a patient with a realistic delusion may believe that they have contracted bird mites from their farm animals, whereas a patient with a bizarre delusion may believe that they have millions of parasites pouring out of their orifices. Patients whose delusions are bizarre and global should be referred to MHPs.

Lastly, the dermatologist should assess the degree of delusion. Not every patient who presents with erroneous complaints of parasites is completely delusional; some are at an early stage of becoming delusional where they may retain significant insight. The Koo-Brownstone staging system illustrates the stages of delusion, from the earlier stage

where the patient does not firmly hold the belief that they are infested to the terminal stages where the patient's belief is unshakeable.[2] If the patient has not yet become fully delusional (stage 1 (formication only), stage 2 (overvalued ideation), or stage 3 (delusionoid ideation) – these stages are not yet fully delusional), then they are more likely to be a candidate for management in dermatology. Stage 4 (truly delusional) can be managed in a dermatology setting depending on the dermatologist's skills, but stage 5 (terminal and hopelessly delusional) patients need MHP referral.

Figure 1 depicts our algorithm for determining when to refer DoP patients to MHPs. The authors hope that this algorithm may be useful in distinguishing patients who can be successfully managed within the dermatology setting from those who need mental health referral.

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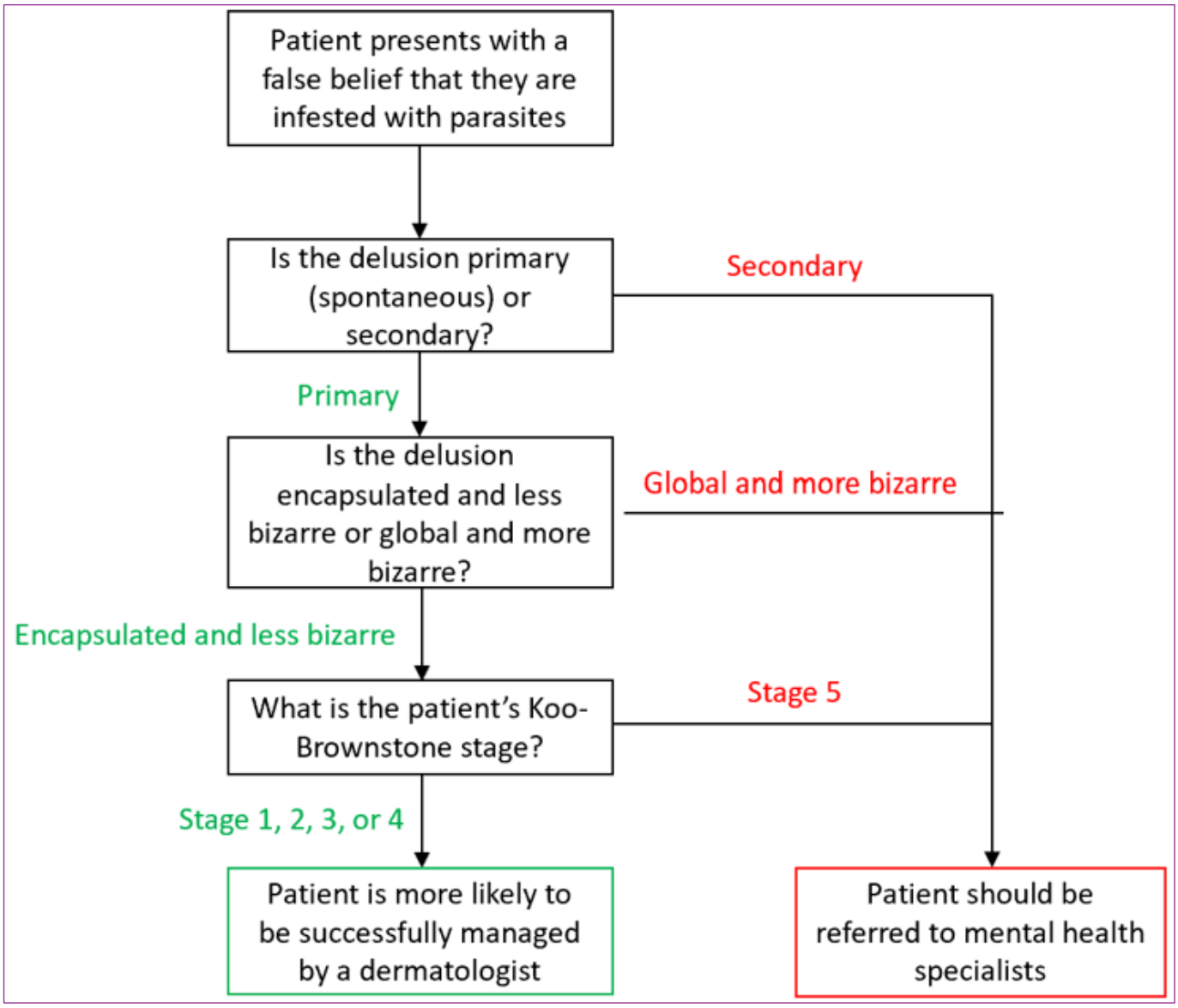

Figure 1. An algorithm to determine whether or not a patient with DoP needs a mental health referral.