

MULTIDISCIPLINARY FOLLOW-UP OF EKBOM SYNDROME: A SYSTEMATIC REVIEW

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Abstract: Parasitic delirium, known by its clinical term Ekbom Syndrome, is a rare and chronic disease characterized by the certainty of infestation of the individual by parasites, without any medical confirmation for this. Because of this, self-mutilation is often associated. In addition to the detailed description of the parasite made by patients, such as its structure and path on the skin, it is also common for them to bring pieces of objects simulating to be the animal to the medical consultation. Due to its complexity, both diagnostic and management, the individual from the beginning goes through multiple spheres of care, requiring interconnection between each one for comprehensive care. The present work aims to discuss the pathology itself, in addition to promoting a reflection on the importance of universal acceptance of the individual, Introduction: Ekbom Syndrome (ES), also known as dermatozoic delusion, psychogenic parasitosis or parasitic delusion (PD), is a condition characterized by an individual's own delusional, phobic-obsessive perception that his body is infested by parasites. The infestation reported by the patient can be described by tactile sensations (such as itching and burning) and visual sensations, in their various settings. Generally, the dermatology outpatient clinic and medical clinic are the first ones sought by the patient, whether just because of the belief in the presence of a parasite on their skin, or because of the association with self-mutilation resulting from the perceived discomfort, which manifests itself as lesions of the dermatitis artefacta type. Therefore, it is extremely important to understand the subjectivity of each patient, valuing their trajectory and their relationship with the disease. Objective: Since it is a disease unknown by many professionals, whose diagnosis is eminently clinical and of exclusion, the objective is to study the clinical picture of Ekbom Syndrome and its

broad management. **Materials and Methods:** This is a systematic review of case reports without meta-analysis that used the Medline, UpToDate and Scielo databases to perform a search based on the following descriptors: Ekbom syndrome; parasitic delirium; dermatozoic delirium; delirium of infestation; self-mutilation. Inclusion criteria were articles published in the last 10 years, available online, written in English and Portuguese, totaling 6 articles used in this work. **Results:** The pathophysiology of Ekbom Syndrome is not well understood. However, there are theories about it, one of them being the involvement of lesions in brain areas such as the subcortical, temporal, limbic system and posterior regions of the left hemisphere. Regarding its prevalence, since PD is a rare syndrome, there are 83.21 cases per million inhabitants, with a higher incidence in women (3:1 men), over 50 years old, Caucasians and usually affects more individuals subject to social isolation. However, it is considered an underreported condition due to its complex management. ES can be classified as primary, which is idiopathic, and secondary, which is divided into functional (from presumed psychiatric causes such as schizophrenia and depression) and organic (diabetes, cerebrovascular accidents, medications, chronic renal failure and others). During the anamnesis of a patient with suspected Ekbom Syndrome, it is necessary to pay attention to the main signs and symptoms that will be reported in the consultation, in addition to carrying out a good anamnesis and physical examination. The most common clinical picture that will be described during the approach has an insidious onset, with the patient correlating the appearance of parasites after some significant event (occasional sexual intercourse, contact with animals or proliferation of insects in their home); and with that, the patient may refer to rashes, pruritus, sensation of stinging

or crawling on the skin and paresthesia that usually last from six months to years until the diagnosis is established. This delay is justified by the widespread lack of knowledge of physicians in general about this condition, which causes the patient to have a history of previous inadequate evaluations by dermatologists and general practitioners, and they may also report the use of dermatological and anti-infective therapies even without a previously closed diagnosis. Furthermore, the individual affected by PD usually brings detailed morphological characteristics and the life cycle of the parasites to the consultation, with examples of infested areas being the scalp, mouth, eyes, genital region or below the epidermis. In many cases, the "Matchbox sign" can be observed, which consists of the collection made by the patient himself of debris, scaly tissue, hair, crusts and other substances that adhere to the lesions (remains of tissue, parts insects, dust and others), and keep them in boxes or plastic bags, stating that the parasites are there. This happens because patients obstinately want to convince others about the reality of their parasitic delusion. As the diagnosis is made by excluding other pathologies, patients must be carefully evaluated, ruling out true parasitic infections, hypochondriasis and manifestations of other psychiatric conditions or general medical conditions (secondary delusional infestation). Complementary investigation is done through laboratory tests, blood tests, including urinalysis, liver function, thyroid, electrolytes, blood glucose, liver function and serum levels of Vitamin B12 and folate - especially when a case is more suggestive of an organic disorder. Other exams that can be used in cases of hypothesized dementia syndromes are the MMSE (Mini Mental State Examination) and imaging exams. The therapeutic approach, in addition to all patient follow-up, must be multisectoral, so that a bond of trust is created

between the patient and the professionals. The importance of a general understanding of the condition is based on the objective of accepting the subject's discomforts, frustrations and emotions in relation to their condition, always considering their unique aspects. Associated with this, early referral to a psychiatrist and psychotherapy is paramount as part of the multidisciplinary approach and therapeutic plan. It is worth noting that there are cases in which the patient is intolerant to antipsychotic medications, which are of fundamental importance for the improvement of the clinical condition of the patient. Therefore, in these situations, the option is chosen to follow the treatment only with sessions of cognitive-behavioral therapy (CBT), which is the most indicated psychotherapeutic lineage in the treatment of

anxiety and anguish symptoms. Conclusion: From the analyzed literature, it becomes noticeable that Ekbohm Syndrome is complex and demands comprehensive care for the patient. In addition, because many issues have not yet been clarified about it, it is important to promote in-depth research on the disease, in order to obtain an adequate investigation, considering that the diagnosis of exclusion is an extremely relevant pillar in identifying the condition. Because one of its main characteristics is pruritus, epidermal lesions associated with delusions, hallucinations and may be related to secondary causes, the patient needs to be followed up by a multidisciplinary team, making it essential that the follow-up of the syndrome be of the comprehensive knowledge of different specialties.

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