

A Case of an RLS Mimic Treated with an Antipsychotic

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Abstract

This case reports on a restless leg syndrome mimic that has responded to antipsychotic medication.

Keywords: Sleep medicine; Restless leg syndrome; Delusional parasitosis

Introduction

We report the case of a restless leg syndrome mimic that has responded to an antipsychotic medication.

Case Report

The patient, KC, was referred to our clinic for “anxiety and RLS”. KC is a 61 year old female who is divorced and lives by herself. She has had ongoing sleep difficulties for years. She has been seen by 4 sleep physicians (including a respirologist, a neurologist and a psychiatrist) over the past 3 years for her sleep complaints.

She described difficulties initiating sleep as a result of recurrent and unpleasant sensations in both left and right legs (she would refer to the sensations as “something stings”) with an urge to move when lying down on a bed or a couch or when sitting down on a toilet. The symptoms improved when moving and the symptoms were worse at night. Her complaints have been ongoing for the last 3 years. She has been tried on the following medications: Ropinirole up to 4 mg a day, Pramipexole up to 2 mg a day, Clonazepam up to 4 mg a day, Gabapentin up to 2400 mg a day, and Oxycodone 20 mg a day.

All medication trials lasted for at least 3-4 weeks. She had no family history of RLS. Her alcohol intake was half a glass of wine a day. She was on the following medications: Metoprolol 20 mg for hypertension, and Ranitidine 150 mg for GERD. On physical exam, there was no evidence of peripheral neuropathy. Her score on the MMSE was 30/30. Her EMG did not reveal any abnormalities. Her ferritin level was 75. The sleep study that she had done in 2010 reported “No evidence of sleep related breathing disorder and no evidence of sleep related movement disorder”.

Her psychiatric screen did not reveal any evidence of pervasive depression or anxiety. Her Center for Epidemiologic Studies Depression (CES-D) scale score was 10 and her Zung anxiety scale score was 14. When I explored with her the history of onset of the RLS symptoms she talked about a time when she travelled to Italy, 3 years earlier, and it was during that period that she started experiencing these symptoms.

She talked about “something” that happened when she used a public washroom and felt that something “pinched” her in the

buttocks when she sat down on the toilet seat. She definitely attributed this incident to her symptoms as she was not able to sleep that night because of the “pinching sensation”. Since that time, she has become convinced that “something” has entered her body and resulted in the RLS symptoms.

She was referred to an infectious disease specialist who confirmed the diagnosis as delusional parasitosis, based on her clinical presentation and lack of any evidence of a skin infestation. He initiated treatment with Risperidone 0.5 mg to help her “anxiety and possible skin irritation”. The patient was seen in follow up 2 weeks later as well 2 months later, and she indicated that her RLS symptoms have gotten better as she was able to fall asleep. She was still convinced of “the sting”. She was scheduled for a 6 month follow up but she was a no show. The patient has been lost to follow up since then.

Discussion

To our knowledge this is the first reported case of a patient who presents with RLS like symptoms as a result of delusional disorder – likely delusional parasitosis. Ekbom syndrome (ES) is the clinical term used to describe a delusional disorder with the perception that one’s body is infested by insects despite the evidence to the contrary. These infestations are usually tactile but could be visual as well. It is important not to confuse this term with Wittmaack-Ekbom syndrome that describes restless leg syndrome. It is reported that there are over 25000 ES sufferers in the United States [1].

Various causes [2] have been attributed to this syndrome including physical (Environmental insulation material and allergens), physiological (diabetic neuropathy, hypertensive pruritis, medication induced paresthesia, drug related formication, and neurological insults), psychological (depression, anxiety and psychotic states).

Treatment strategies [3] are that patients not to be confronted with their diagnosis. The focus of treatment strategies should involve empathic listening (not validating the delusion but rather their suffering and experience), and how to improve their quality of life. Providing adjunctive therapy to reduce pruritis and insomnia (hydroxyzine and doxepin) might be warranted. The use of antipsychotics and antidepressants (quetiapine, risperidone, haloperidol, sertraline, fluoxetine and duloxetine) has been reported in the literature with variable results.

References

1. Trabert W (1995) 100 years of delusional parasitosis. Meta-analysis of 1,223 case reports. See comment in PubMed Commons below Psychopathology 28: 238-246.
2. Hinkle NC (2010) Ekbom syndrome: the challenge of "invisible bug" infestations. See comment in PubMed Commons below Annu Rev Entomol 55: 77-94.
3. Freudenmann RW, Lepping P (2009) Delusional infestation. See comment in PubMed Commons below Clin Microbiol Rev 22: 690-732.