

Dermatitis Artefacta : Case Report and Review of Literature

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Abstract—*Dermatitis artefacta is a self-inflicted dermatologic injury with underlying primary psychiatric condition. Precipitating factors ranges from simple anxiety to interpersonal conflicts and several personality disorders including obsessive compulsive disorder, depression and psychotic disturbances. The diagnosis of this entity is often missed. Herein, we are reporting a case of dermatitis artefacta with description of its various manifestations.*

Key words: *Psychodermatology, Dermatitis Artefacta, Factitious Disorders, Liaison Psychiatry*

I. INTRODUCTION

Psychodermatology encompasses a group of disorders prevailing on the boundary between psychiatry and dermatology. Although there is no universally accepted classification, the most accepted system is that devised by Koo and Lee in the year 2003¹ comprising of:

- 1) Psycho physiological disorders: psoriasis, atopic dermatitis, acne excoriee, hyperhidrosis, urticaria, herpes simplex virus infections, seborrheic dermatitis, aphthosis, rosacea, pruritus.
- 2) Psychiatric disorders with dermatological manifestations (primary psychiatric): dermatitis artefacta, delusion of parasitosis, trichotillomania, obsessive compulsive disorders, phobic disorders, dysmorphophobia, eating disorders, neurotic excoriation, psychogenic pruritus.
- 3) Dermatological disorders with psychiatric symptoms (primary dermatologic): alopecia areata, vitiligo, generalized psoriasis, chronic eczema, ichthyosiform syndromes, rhinophyma, neurofibroma, albinism.
- 4) Miscellaneous: a) cutaneous sensory syndromes: glossodynia, vulvodinia, chronic itching in scalp, b) psychogenic purpura syndrome, c) pseudo-psycho dermatologic disease, d) suicide in dermatology patients.

Herein we are reporting a case of dermatitis artefacta along with obsessive compulsive disorder as a primary psychiatry disorder.

II. METHODOLOGY

A hospital based case report observational study was conducted on a rare and interesting case of Dermatitis Artefacta attended on dermatology department of Skin and VD, S.M.S. Medical College, Jaipur (Rajasthan) India. This case was entered, examined and investigated in details.

III. CASE REPORT

A 17 yr old male presented to the department of dermatology, STD and leprosy, S.M.S. Medical college, Jaipur, with multiple painful, linear to irregular raw and crusted areas over body with sparing of face and back since 25 days (figure 1 and figure 2), the cause of which he could not explain.

Figure 1

Irregular raw and crusted areas on Arm and Chest

Figure 2

Irregular raw and crusted areas on Thigh

Figure 3

Irregular raw and crusted areas on Arm and Chest

Figure 4

Irregular raw and crusted areas on Thigh

There was no history of trauma or any external injury. Since 2 years patient was also taking antidepressant medications for obsessive compulsive disorder in form of oral fluoxetine 60mg daily and clonazepam 0.5mg on SOS basis. Dermatological examination revealed multiple well defined linear to irregular erosions and crusted plaques of size varying from 2x5 cm to 5x10 cm distributed bilaterally symmetrical all over the body with sparing of face and back of trunk. Lesions were confined to accessible sites. Routine laboratory and specialized investigations were performed to rule out other causes of similar lesions including vasculitis, bullous skin disease, infestations and diabetes mellitus. Thus, a diagnosis of dermatitis artefacta was made based on clinical findings by exclusion

IV. DISCUSSION

Dermatitis artefacta, a form of factitious disorder involves self inflicted cutaneous lesions that the patient typically denies having induced. In 1922, Sir Norman Walker stated that “neither rank, education, intelligence, devotion to duty nor the most exemplary character excludes the possibility of self infliction.²The prevalence varies from 0.05 to 0.4%.³

The condition is more common in women than men (3:1 to 20:1) with highest prevalence for onset between adolescence and early adulthood.

The DSM-IV-TR criteria for factitious disorder⁴include a) intentional feigning of physical or psychological signs or symptoms, b) the motivation is to assume sick role c) external incentives for the behavior (such as economic gain, avoiding legal responsibility or improving physical well being) are absent.

Majority of the patients presents with a vague history, with insufficient details and typically denies any role in the production of lesions.

The lesions are usually bilaterally symmetrical most commonly involving face followed by dorsum of hands and forearm, within easy reach of dominant hand, and may have bizarre shapes with sharp geometrical or angular borders or they may be in the form of burn scars, purpura, blisters and non-healing ulcers. Erythema and oedema may be present. Self-inflicted chemical burn may show a “drip-sign”. Punched-out necrotic areas or uniform circular blisters or erosions are typical of cigarette burns. Oedema of limbs from tied bands is described as secretan’s syndrome.⁵Dermal induration and necrosis can occur from foreign body injection of milk, oil, or grease into breasts, thighs, abdomen and penis.⁶

Reported associations include obsessive compulsive disorder, borderline personality disorder, depression, psychosis, physical or sexual abuse and mental retardation.

Dermatologic differential diagnosis include necrotizing vasculitis, bullous skin disease, pyoderma gangrenosum, other types of vasculitis, physical abuse, collagen vascular disease and infestation.

Psychiatric differential diagnosis includes delusion of parasitosis, dermatitis para-artefacta, delusion of parasitosis Munchausen’s syndrome, Munchausen syndrome by proxy and malingering

Doctor should avoid immediate confrontation regarding the suspicion that the lesions are self-inflicted⁷ Liaison psychiatry, through its multidisciplinary approach involving the dermatologist, psychiatrist and the patient’s family physician can confirm the diagnosis of dermatitis artefacta and provide necessary psychotherapy. Dermatological management of cutaneous wound includes debridement and irrigation, topical antibiotics, oral antibiotics or antifungal medications. Occlusive dressings may be used to prevent further cutaneous damage.

Psychiatric treatment includes a combination of behavioral and pharmacological therapies. Selective serotonin reuptake inhibitors (SSRIs)⁸ such as fluoxetine, sertraline, paroxetine and fluvoxamine are typically first-line treatment for compulsive behavior whereas anxiolytics such as buspirone and benzodiazepines are prescribed if anxiety is a dominant presentation. Other therapies include cognitive therapy, behavior modification, hypnosis, eclectic approach and psychodynamic psychotherapy.

CONFLICT OF INTEREST

None declared till now.

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