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Original Research Article

Dermatitis Artefacta: A Fictitious Skin Condition?

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Abstract:

Primary psychiatric conditions encountered in dermatology include dermatitis artefacta, trichotillomania and neurotic excoriations. Dermatitis artefacta (DA) is a psychocutaneous disorder where the skin lesions are self-induced to satisfy an unconscious psychological or emotional need. The patients usually hide the responsibility for their actions from their doctors. Dermatitis artefacta should enter the differential diagnosis of every chronic, puzzling, and recurrent dermatoses.

Keywords: Psychiatric, Artefacta, Puzzling, Dermatoses.

Introduction

Dermatitis artefacta or factitious dermatitis is a psychocutaneous disorder in which the patients consciously create lesions in skin, hair, nail, or mucosae to satisfy a psychological need, attract attention, or evade responsibility. A high index of suspicion is required to diagnose the condition because the history is often vague as patients dissociate while they self-abuse [1]. Often, the psychological need is typically one of being taken care of by assuming the role of the sick patient [2].

Aim

The aim of the study is to assess whether dermatitis artefacta is a fictitious skin condition or an actual skin ailment like any other chronic recurrent dermatoses.

Material and Method

Study was carried out in the out-patient department of dermatology at Jawaharlal Nehru medical college and hospital, Bhagalpur, Bihar for a period of 1 year from March 2018 to February 2019 and included all the primary psychiatric conditions visiting us for treatment. All the patients included in our study were subjected to elaborate history taking sessions and biopsy if necessary, so as to rule out any other dermatoses before making a conclusive diagnosis of dermatitis artefacta as it is a diagnosis of exclusion.

Result

The history taking sessions of these patients revealed emotional immaturity in patients of younger age group and disturbed interpersonal relations or tragedy in the form of death or separation of a family member in patients of older age group as the inciting factor leading to self-abuse thereby proving that dermatitis artefacta is a psychocutaneous disorder.

Etiology

The patient induces the lesions to satisfy an internal psychological need, which is often the need to be noticed or to receive care. Unlike malingering, there is no direct benefit sought from induction of the skin lesions. Various psychosocial conflicts, emotional immaturity, unconscious motivations, and disturbed interpersonal relations have been implicated as the etiological factors [3].

Epidemiology

This disorder is seen more commonly in women (male to female ratio of at least 1:4), and has a broad and variable age of onset (9–73 years), with the highest frequency during adolescence and young adulthood. The prevalence is about 0.3% among dermatology patients [4]. One study of patients presenting with primary psychiatric conditions to dermatology clinics found that one-third patients had dermatitis artefacta [5].

Pathophysiology

Adults with the disease may have associated neurosis, personality disorders, impulsiveness, or depression. The patients may assume a sick role which may allow avoidance of adult

responsibilities. There may be associated self-hate and guilt. Children may have associated anxiety or immature coping styles to various psychosocial stresses. The patient population is also associated with working in or having family members in health-related careers. This may be related to the hypochondriacal tendencies of the patient or that the patient is inclined to learn to falsify ailment through contact with those with actual disease [6].

Presentation

Patients with dermatitis artefacta frequently present with a vague history, with insufficient details of how the skin lesions first appeared. Often, the patient appears unmoved by the unsightly and bizarre lesions. In contrast, their families are often upset and are critical of how the lesions evolved [7].

The lesions of dermatitis artefacta themselves are varied as different instruments and methods are used to produce them. However, the lesions tend to be on normal skin and have an atypical morphology without recognizable characteristics of dermatosis. The shape of the lesions may be geometric, angulated, necrotic or appear as linear streaks secondary to application of harmful liquids. Lesions are always self-inflicted and the morphology varies widely depending on the mode of injury: cutting, abrasion, burning, applying chemicals, and injecting various products. Bizarre lesions with sharp geometric borders surrounded by normal skin are characteristic of DA [8].

The various methods of producing the skin lesions are highly imaginative and depend on the patient's background and education. Lesions may be produced by a variety of mechanical or chemical means, including fingernails, sharp or blunt objects, burning cigarettes and caustic chemicals [9]. In the right right-handed person, the left side is usually involved and the accessible body parts are usually involved than inaccessible part like midline of back [10]. Recurrent excoriation produces inflammation and lichenification of the skin; the resultant irritation and pruritus leads to furthertrauma and chronic dermatitis [4].

The attending dermatologist often notices that the patient enters the examination room with numerous previous investigative reports and medications. During the history taking session, constant rubbing or picking of the lesions is not uncommon. Except amnesia about the act, other signature signs are bizarre-shaped lesions with various stages of healing; involvement of approachable body parts, normal intervening skin; nonspecific histology; normal blood test; and most importantly complete disappearance of the lesions under occlusion therapy. Basically, it is a disease of exclusion that presents as numerous dermatological diseases [11]. Two clinical pictures of a patient presenting with dermatitis artefacta to our out-patient department have been included below to highlight the characteristic findings of a typical case which can be really helpful in suspecting and diagnosing this condition.

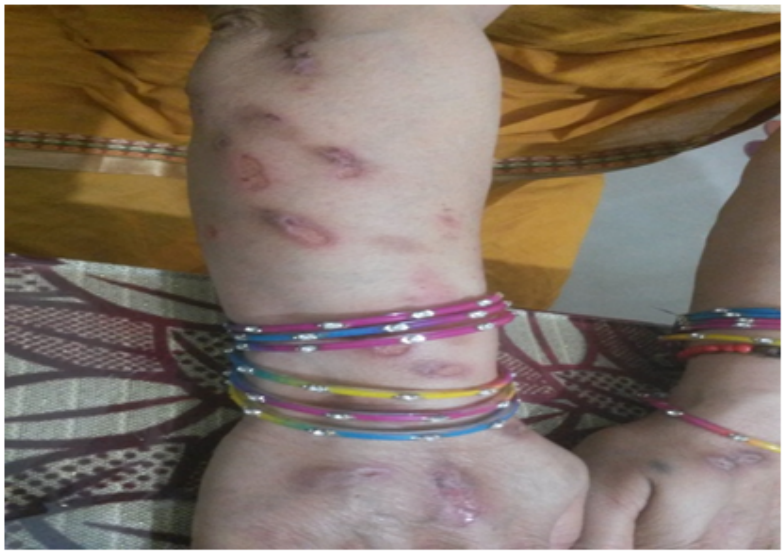

Figure 1: Bizarre linear tapering lesions situated over extensor aspect of her right forearm along longitudinal axis

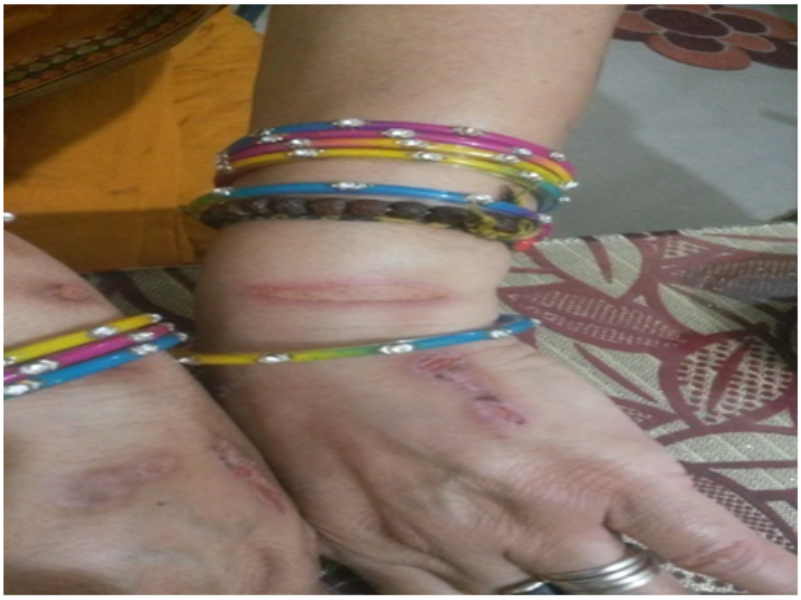

Figure 2: Lesions at various stages of healing as depicted by simultaneous presence of a recent erosion, an almost healed erosion and an old scarred lesion situated side by side

Histopathology

Histopathological features are non-specific and usually show features of acute inflammation with increased polymorphonuclear leucocytes and scattered erythrocytes. There may also be areas of necrosis with areas of healing and fibrocystic reaction [12].

Differential Diagnosis

Dermatological and psychiatric differential diagnosis may be considered. The most common differential diagnosis for dermatitis artefacta is necrotizing vasculitis. Other dermatologic considerations include bullous skin disease, pyoderma gangrenosum, other types of vasculitis, collagen vascular disease and infestation [13,14]. Psychiatric differential diagnosis that may be considered include delusions of parasitosis, obsessive-compulsive disorder (OCD), Munchausen's syndrome, Munchausen syndrome by proxy and malingering [15].

Management

Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, sertraline, paroxetine and fluvoxamine, in possibly high doses, are typically first-line treatment for compulsive, self-injurious behaviour. Anxiolytics such as buspirone and benzodiazepines can be prescribed if anxiety is a dominant feature. Atypical antipsychotics such as pimozide, olanzapine or risperidone can be helpful in treating the self-injurious behaviour, and may be used alone or in combination with a SSRI [15]. Specific dermatologic measures for treatment of the cutaneous wounds include debridement and irrigation, topical antibiotics, oral antibiotics or antifungal medications depending upon the type of accompanying infection [16]. Occlusive dressing may be used to avert further cutaneous damage. Analgesics can be prescribed with caution as the patient may be vulnerable to drug abuse.

The need for psychiatric referral should be balanced against the fact that the patient will interpret this referral as a rejection, which can intensify the self-mutilation. Follow-up studies have shown that most patients with DA improve significantly with changes in life situation and maturation than as a result of psychiatric treatment [17].

Prognosis

For patients with mild cases of dermatitis artefacta associated with common stressors like anxiety or depression, the prognosis is good. However chronic cases of dermatitis artefacta that are associated with medical problems and chronic skin damage usually have a guarded outcome. When the condition is left untreated, it can lead to severe self-mutilation and poor aesthetics with disfiguring scars. Initial strong therapeutic alliance with the patient, in terms of mutual trust and rapport, is very crucial for a better outcome as prognosis of the disease is not good with frequent waxing and waning [15].

Conclusion

Dermatitis artefacta is a long-term disorder, and patients need regular follow up with a dermatologist and a psychiatrist because relapses are common. Many patients are noncompliant with treatment and often fail to follow up. Although the underlying cause of dermatitis artefacta is of a psychiatric nature, patients with this disorder frequently seek help from dermatologists as they are unable to acknowledge that they are inducing

the physical lesions on their own. The visible skin lesions can be understood as an attempt at non-verbal communication subserving an appeal function [18]. Therefore it is often a challenge for the attending dermatologists because of its rarity, vague history, bizarre and polymorphic morphology, lack of decisive diagnostic tests, and poor therapeutic outcomes.

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