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The Importance of Psychodermatological Approach in Diagnosis of a Factitious Disorder: A Case Report of Dermatitis Artefacta

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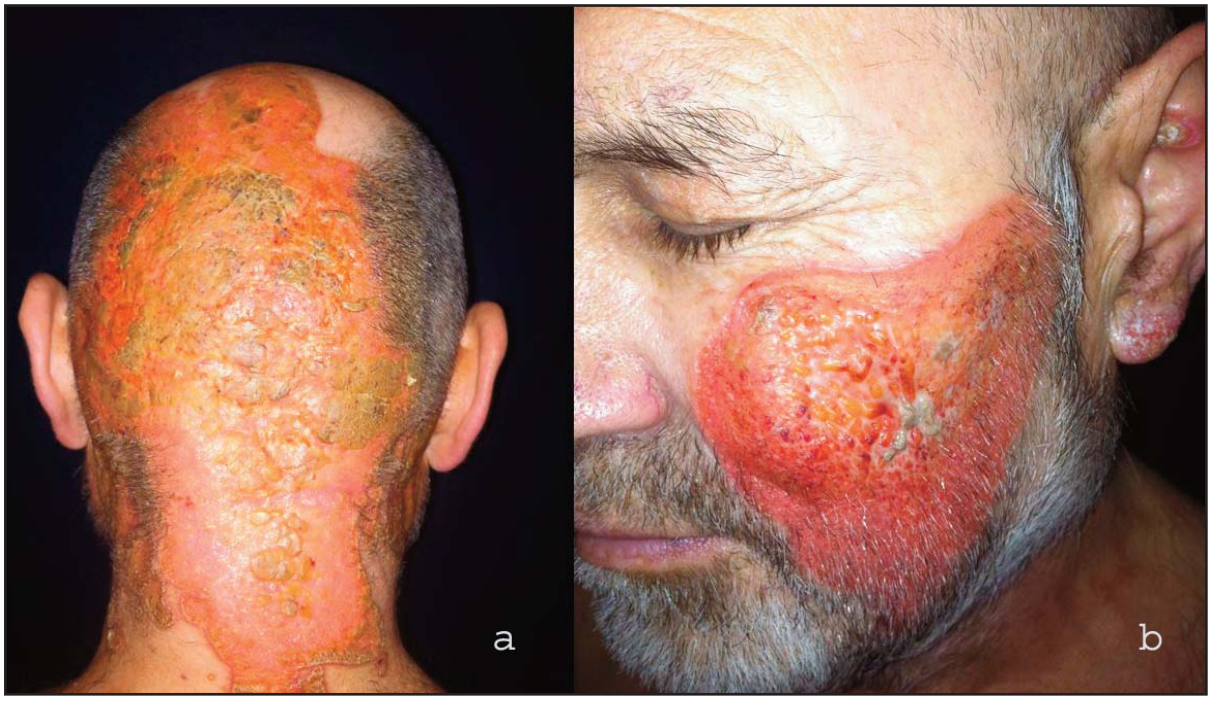
Abstract

Observation: Dermatitis artefacta is a psychocutaneous disorder which includes both psychiatric and dermatologic pathologies. It is known to be a rare and difficult condition for diagnosis and treatment mostly because of the patient's denial. It consists of self-induced skin lesions often involving a more elaborate method for damaging the skin, such as the use of a sharp instrument. We present a fifty nine-year-old psychotic male patient with unusual skin lesions which has gone undiagnosed for a long time as well as severe anemia. Diagnosis of DA was made by efforts of a psychodermatologic team work. We emphasize the diagnosis of patients with DA is challenging as many patients fail to engage effectively with their dermatologist.

Introduction

Factitious disorders are artificial or faked diseases that may be seen in the fields of psychiatry and all somatic specialties [1]. In this disorder, patients intentionally produce mental and/or somatic problems without clear identifiable rewards [2]. However, these patients are motivated by an internal, mainly unconcious determinant than an external incentive, such as satisfying an unconcious psychological or emotional need. Many examples of simulated or self-provoked disorders have been reported in various medical branches from feigned anemia, fever to pseudodementia in medical literature [3]. Generally, many of cases are unusual and have multiple diagnostic tests and treatments without a spesific diagnosis.

Dermatology is particularly concerned with factitious disorders due to both the easy access to the skin and the visibility (easy noticeability) of feigned problems. The term of dermatitis artefacta (DA) or factitial dermatitis, is used for the simulated skin disorder [4]. Therefore, DA is a psychocutaneous disorder which includes both psychiatric and dermatologic pathologies. It is cited in the subgroup of primary psychiatric disorders of psychodermatologic diseases in dermatology [5]. While cutaneous lesions are unfamiliar for psychiatrists, psychiatric problems may



Figures 1a and b. Widespread ulceration on the scalp area and the cheek

not be noticeable for dermatologists. Thereby, diagnostic and therapeutic procedurs for this entity needs a strong colloboration among dermatologists and psychiatrists and the best a psychodermatologic approach.

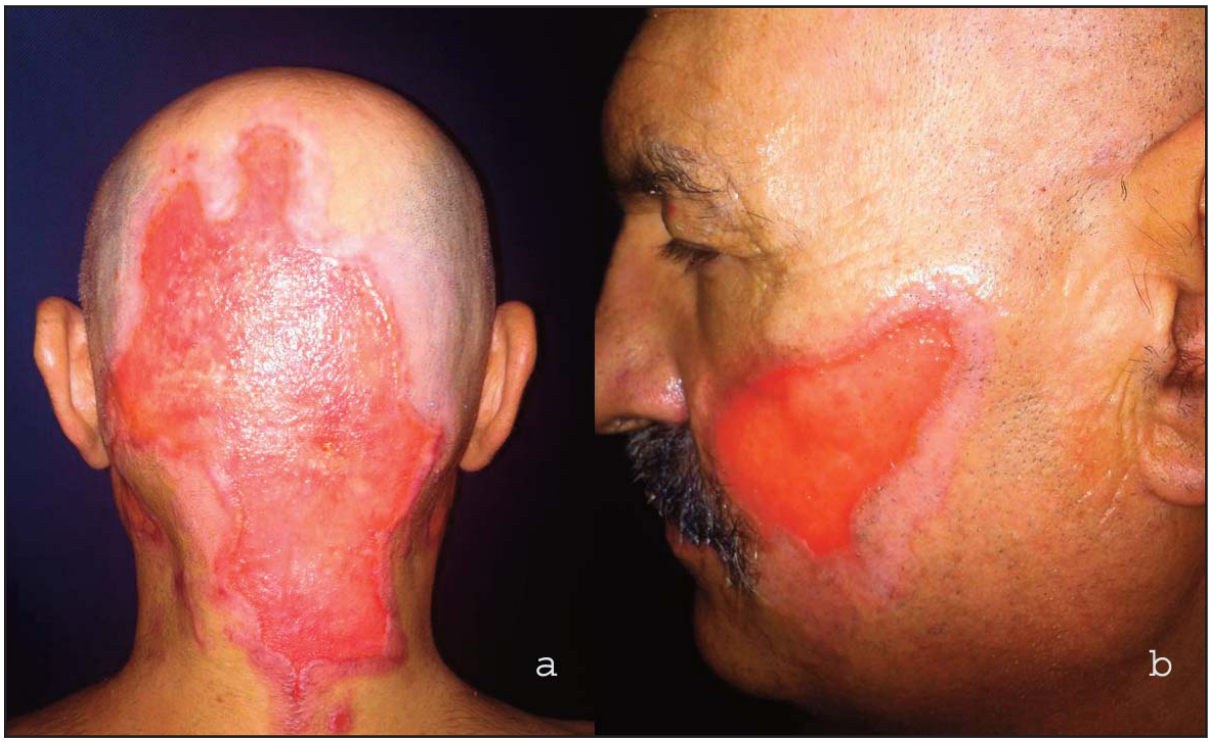
Herein we present a psychotic male patient with unusual skin lesions which has gone undiagnosed for a long time as well as severe anemia. Diagnosis of DA was made by efforts of a psychodermatologic team work.

Case Report

A fifty nine-year-old male was admitted to the Department of Internal Medicine in our hospital due to severe anemia. As diagnostic investigations of anemia were continuing in that clinic, he was consulted to us because of the ulcerations located on the face and scalp. His medical history revealed that the first symptoms at these locations had appeared 8 years ago after his wife's death and since then he has applied to various medical centers for a cure. The patient was unable to accurately describe how the lesions began. He had 4 biopsies from the skin lesions for histopatological examinations, as well as multiple microbiological tests in the past. He had a bag including a lot of creams and was rubbing all of them on his wounds. These creams included corticosteroids, antibiotics and also epithelizing substances, but none of these medications has not provided any positive clinical result. His renal and hepatic functions and electrolytes were all in normal limits. There was only a severe anemia in his laboratory examination with a hemoglobine value of 5.5 mg/dl. In spite of all these diagnostic procedures the final diagnosis had not been established. During his hospitalization in that clinic, he was given 4 units of erythrocyte suspension because of his anemia. His hemoglobine was increased from 5.5 to 9.7 mg/dl. Gastroscopy revealed erythematous pangastritis. Although colonoscopy was planned three times, it could not be performed because he insisted eating something before the procedure despite all cautions. Finally, he was transferred to our clinic for his cutaneous lesions. At the day of admission to our department dermatologic examination revealed widespread exulceration from vertex to occipital region on his scalp with an active, slightly elevated and squamous border on the neck and multiple various sized ulcers with irregular borders on the cheeks, forehead and postauricular regions (**Figures 1a and b**).

Ulceration on the scalp was unusually wide and covered with a yellowish-gray material and bleeding points. It had a clear, flat border on the nape. He reported the skin lesions being painful and he was habitually taking painkillers for this reason.

The appearance of the lesions seemed like necrobiosis lipoidica, lupus vulgaris, discoid lupus or sarcoidosis, although past biopsies did not supported any of these diseases. Again, skin biopsies



Figures 2a and b. After 3 weeks, epithelization of the lesions

encompassing some different areas (border, ulceration and face) were taken. Histopathological examinations in the past had showed chronic inflammation, the existence of plasma cells in the subcutaneous fat tissue. Necrobiotic collagen bundles, many bacteries, epidermal erosion were seen in the most recent histopatohological slides and these findings were also not consistent with none of given diagnoses. Pathologist explained that these changes might be secondary to trauma and they didn't define any specific dermatological disorder. Afterwards, the existence of flat and clear borders in the ulceration, of a hollow history and many medical investigations without any positive significant finding, suggested that this might be a case of factitious disorder

Thus, we decided to observe the patient closely and to deepen the interviews by clinical psychologist and psychiatrist. His family (he had a son and had lost his wife) was contacted. Close observation and multiple interviews revealed that he never goes out without a pocket mirror, a pen and a gun. He was scratching his scalp everyday with a razor blade and he was applying lots of leeches on his body three times a week during the last 5 months in order to remove the 'dirty blood'. At first he certainly denied any intervention to his skin like scratching or irritating, but repeated questioning provided his confession. Razor blades were found in his drawer which explained bleeding points and clear-cut borders of cutaneous lesions. He used razor blade and by using a mirror he reached the back of the scalp.

In psychiatric evaluation, the patient was diagnosed with psychosis showing anti-social features, having problems with human relations and anger management. He had an impaired sense of reality and judgment with regard to his delusional issues, but his ability of abstract thinking was normal The patient was treated with risperidone 2mg/daily, biperidene hydrochloride 2 mg/daily and fusidic acid cream under occlusion. After 3 weeks, his lesions started to epithelize (**Figures 2a and b**). One month after discharge, a good clinical response occurred.

Discussion

Factitious disorders in dermatology are considered in the category of self-inflicted or self-injurious skin lesions [**6**]. DA is seen more commonly in women than men and with a female to male ratio varying between 3 to 1 and 20 to 1 [**7**] , with a broad and variable age of onset (9 to 73 years) [**8**]. The onset of the disease is usually between adolescence and early adulthood, but it can affect any age [**9**]. Our patient was a male with a relatively late onset. In a study about patients presenting with primary psychiatric conditions to dermatology clinics, it is found that one-third of pa-

tients had DA [**7**] and the prevalence is approximately 0.3 % among dermatology patients [**10, 11**]. The patients deny the responsibility, as our patient who first denied but finally admitted self mutilation which is typical for DA [**12**].

Patients usually present with a history of non-healing lesions and insufficient anamnesis about how the lesions appear. Self-inflicted skin lesions are in geometric or bizarre pattern with linear and sharp borders surrounded by normal skin [**13**] and have an atypical morphology unsuitable with characteristics of any other dermatoses. They can be produced by different instruments including fingernails, sharp or blunt objects, burning cigarettes and caustic chemicals [**6, 13**]. Patients can create new lesions on their own by cutting, burning, scratching, punching, sucking, biting and scraping. Our patient was using a razor blade to scratch his scalp.

Associated psychiatric conditions with DA include obsessive compulsive disorder, borderline personality disorder, depression, psychosis, mental retardation, impulsive behavior and somatization [**14, 15**]. Apparently, a wide spectrum of psychological abnormalities from simple anxiety and depression to severe personality disorders and even to psychotic disturbances can lead to the self-destructive activity [**7, 16, 17**]. In any case, self-inflicted lesions relieve their inner sense of isolation and distress, and help them establish boundaries and fill their emotional emptiness [**7**]. Our patient told us that he has felt very lonely after his wife's death and the lesions began to appear at that time, although he has lived with his son and he has taken care of him. Drainage of the dirty blood relieved him

DA may masquerade as numerous dermatological disorders and, thus should be considered after exclusion of other skin diseases [**11, 16**]. Histopathological features are nonspecific 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 [**4**]. Blood tests or histopathological evaluation do not support any known dermatological disease. These are important clues for the diagnosis of DA. Yet, all these findings may occasionally be attributed to a real disease by dermatologists. Although geometric demarcation lines and angulation exist, clinical lesions actually resembled to some dermatologic diseases in our patient. Possibly, extending of the scalp lesions to the nape and the raised border all around of the ulceration were challenging clinical features. In fact, different methods and variable instruments may be used in creating skin lesions depending on psychopathology. Therefore every case of DA is unique. The question of how patient makes them exist almost all the time.

The most important part of the management of DA is a non-judgemental and supportive approach [**17**]. A good doctor-patient relationship based on a mutual trust can increase compliance with the therapy. Besides, close follow-up is essential to sustain the relationship. *Nielsen* et al. suggest that the dermatologists should not confront the patient with the cause until a good relationship has been established [**18**]. Direct psychiatric referral should be balanced against the fact that the patient will interpret this referral as a rejection, which can intensify the self-mutilation [**11**]. Therefore, a psychodermatologic team work will provide better results in diagnostic period.

Dermatological therapy includes debridement and irrigation, topical antibiotics, oral antibiotics or antifungal medications [**19**]. Occlusive dressings are very important to limit patients' access to the lesions and prevent further damage. Psychiatric treatment includes a combination of pharmacologic therapies and behavioral therapy. Atypical antipsychotics such as pimozide, olanzapine or risperidone can be helpful in treating the self-injurious behavior, and may be used alone or in combination with a SSRI [**7**].

To conclude, factitious disorders are difficult to diagnose and to treat. Early diagnosis is important for not to perform unnecessary tests, therapies or procedurs. Expanding awareness of these disorders is important in the evaluation of any psychiatric patient, as these disorders are basically dermatologic signs of underlying psychopathology. Thus, a team work including dermatologist, psychologist and psychiatrist is essential and also detailed communication with patients

supported by psychological tests, examinations and family interviews are crucial.

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