Dermatitis artefacta in a patient with paranoid syndrome

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Summary

It is well recognized that psychosomatic factors play an important role in many skin diseases. Dermatitis artefacta coexists with quite an extensive number of psychopathologic conditions. In women, it is regarded as a "cry for help," especially when the patient is faced with psychosocial stressors. We present the case of a 40-year-old woman with long lasting self-inflicted excoriations and ulcerations of the skin located within easy reach of her hands. We discuss the reasons for such behavior and the possibilities of dermatological and general interventions.

KEY WORDS

dermatitis artefacta, paranoid syndrome, female patient

Introduction

Psychodermatology covers conditions in which mental and psychiatric disturbances are combined with dermatological diseases. Emotional problems as the cause of skin lesions have been important over the last few years. According to Koo et al., there are four subgroups of psychodermatological conditions: (i) "psychophysiologic disorders," in which the patient's emotional processes determine the severity of the dermatosis; (ii) "psychiatric disorders," in which the disorders precede the self-induced skin injuries; (iii) "secondary psychiatric disorders," in which psychiatric disturbances are secondary to a dermatological disease; and (iv) "cutaneous sensory disorders," in which a patient complains of itching or burning sensations without visible skin lesion manifestations (1). Self-induced dermatitis should be considered when organic disorders have been excluded (2). However, there are many reasons patients may attempt to trick their physicians. The main ones are psychiatric conditions and mental retardation (3).

We present the case of dermatitis artefacta in a woman that had already been diagnosed with a paranoid syndrome.

Case report

A 40-year-old female patient, marital status single, a neurologist currently receiving disability benefits, was

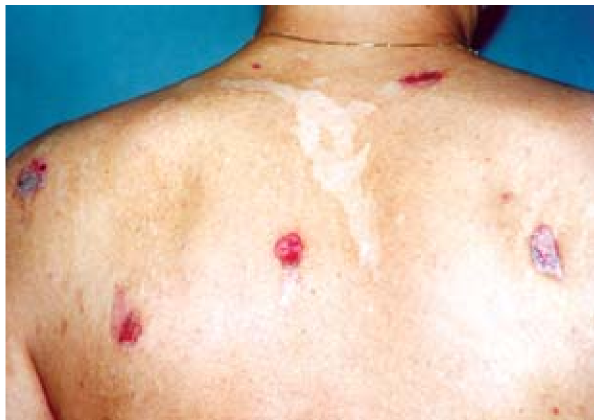

Figure 1. Erosions, ulcerations, and scars on the back (note the straight edges).

referred to the dermatology department by her general physician because of recurrent skin lesions of unknown etiology. The condition had started a few years prior to the referral, following surgical excision of an “abscess” located on her face. Since then, numerous erosions had appeared on her face, and the condition had worsened considerably after she lost her job. The dismissal had resulted from the many problems the patient created at work. Due to psychiatric treatment, she took a long sick leave; after a few months of intensive in-patient and out-patient psychiatric treatment, she was granted disability benefits. While receiving disability benefits, the patient also attended regular follow-ups at a dermatologist, which proved to be ineffective. The patient used to cover the lesions with excessive amounts of cosmetic concealer. She denied any mental problems to the dermatologist, and also refused psychiatric help. Her father reported, however, that she had had psychiatric problems even during her medical studies and had been treated at a psychiatric hospital in 2000, with a diagnosis of severe paranoid syndrome.

After many outpatient dermatological follow-ups, her skin lesions started to heal gradually, but new lesions were also observed. The patient was admitted to the dermatology unit. On clinical examination, numerous erosions and ulcerations with straight edges and sharp angles, of oval, round, and triangular shape were observed (Figure 1). The lesions were located over the patient’s face, ears, upper and lower limbs, and back; the central part of her back was spared. She also had numerous scars.

A skin biopsy did not reveal characteristic features, but only supported the clinical diagnosis of erosion (Figures 2, 3). Laboratory tests such as blood cell count and biochemistry tests were normal. Bacteriological culture of the skin erosions revealed *Acinetobacter*.

While she was in the dermatological hospital, a follow-up visit to the psychiatrist was arranged, which confirmed the diagnosis of paranoid syndrome. Subsequently, systemic treatment with psychotropic drugs (risperidone, dibenzepin hydrochloride, and carbamazepine) was re-introduced. Systemic treatment with antibiotics and antihistamines as well as topical treatment with mild steroids and emollients were also administered. All the drugs were taken under strict surveillance. After ten days of treatment, there was considerable improvement of the patient’s skin lesions and mental health. Currently, the patient is under psychiatric and dermatological care.

Discussion

Self-inflicted skin lesions are also known as dermatitis artefacta, or factitious disorders with physical symp-

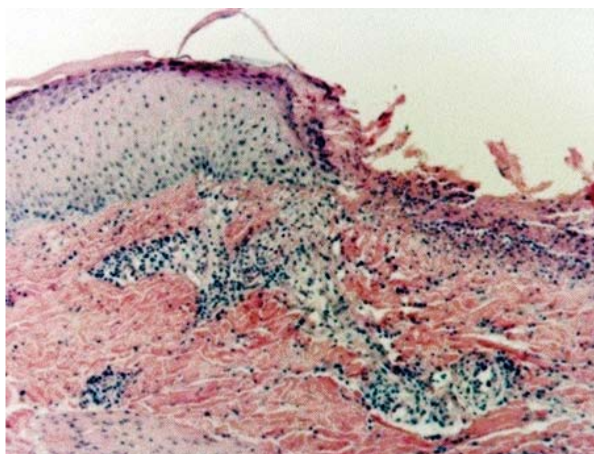

Figure 2. Ulcerative skin lesion; histopathology: erosions, acanthotic epidermis and sparse perivascular infiltrate (hematoxylin-eosin ×100).

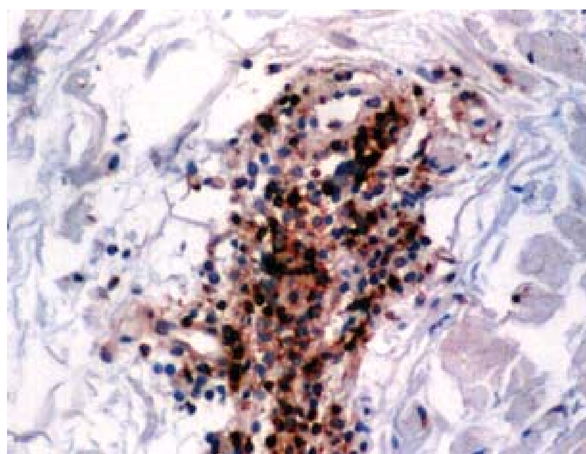

Figure 3. Postinflammatory hyperpigmentation in the skin of the buttocks.

toms (4). They are diagnosed mostly in woman in their twenties and thirties. They account for 0.05–0.5% of dermatological consultations (5). The lesions were mainly confined to the areas located within easy reach of the patient's hands, which is in agreement with reports in the literature (6–10). The constant stress during her medical studies and professional activities further influenced her behavior. Our patient was convinced that her troubles were of dermatological origin and avoided psychiatric follow-ups. She expected effective help from the dermatologist, but did not really follow medical advice and prevented healing by continuous self-manipulation. This situation persisted for many months or even years.

When attending a dermatological consultation, the patient denied any past psychiatric problems or self-mutilation, which seems to be typical for psychiatric conditions. When admitted to the dermatological ward, the skin lesions started to heal under occlusive dressings. It is worth mentioning that such patients present a real challenge to dermatologists. Unfortunately, patients with self-inflicted lesions prefer to consult a dermatologist rather than a psychiatrist.

This case underscores the importance of good cooperation between dermatologists and psychiatrists (11, 12).

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