DOI: 10.5958/j.2319-5886.3.2.102

International Journal of Medical Research & Health Sciences

www.ijmrhs.com Volume 3 Issue 2 (April - Jun) Coden: IJMRHS Copyright @2014 ISSN: 2319-5886

Received: 31st Jan 2014 Revised: 25th Feb 2014 Accepted: 28th Feb 2014

Case report

FACIAL DERMATITIS ARTEFACTA: A RARE PRESENTATION

Ramtanu Bandyopadhyay[1], *Rudrajit Paul[2], Seshadri Sekhar Chatterjee[3], Kaberi Bhattacharya[4], Dilip Mondal[5]

[1]Associate Professor, [2]Assistant Professor, Department of Medicine, Medical College Kolkata, West Bengal, India

[3]Senior Resident, [4]Assistant Professor, [5]Professor, Department of Psychiatry, Medical College Kolkata, West Bengal, India

*Corresponding author email: docr89@gmail.com

ABSTRACT

Dermatitis artefacta (DA) is a rare psycho-cutaneous disorder where bizarre skin lesions are seen in accessible parts of the body. It is common in young females with mental stress. We here report a case of DA from West Bengal. A 16 years old female with depression presented with mainly facial lesions. She responded to psychotherapy. The relevant literature regarding DA and other similar disorders has been also discussed at length.

Keywords: Dermatitis artefacta, Depression, Depigmentation, Face

INTRODUCTION

Dermatitis artefacta is a rare psychiatric disorder where patients deliberately create skin lesions to satisfy an inner psychological urge.[1] Its diagnosis and treatment is often very difficult and frustrating and close association between patient and psychiatrist is needed for a long time.[1] It follows a waxing and waning course. The lesions are usually found in accessible parts of the body and they do not follow any known disease pattern. Often, prolonged diagnostic testing and follow up is done before the disease is actually suspected. We here present a case of facial dermatitis artefacta in a young female. As far as we searched, this is probably the first such case to be reported from West Bengal.

CASE REPORT

A 16 years old unmarried girl, diagnosed as major depressive disorder and on no therapy presently, was brought by her father to the psychiatry outdoors with complaints of multiple, well-demarcated skin lesions on the whole of face, dorsum of bilateral hands and legs (Fig 1). According to her, the lesions initially appeared on her legs and healed by themselves after a few days. Later, similar lesions started appearing on her face. But she could not specify the time.

Cutaneous examination revealed multiple linear fresh lesions with tapering ends on her face involving the bridge of the nose, malar eminences, chin, and also forehead. Skin between the lesions was absolutely normal. Most of the lesions were linear or oval in shape, in various stages of healing. Some of the lesions were healed with scarring and depigmentation. The lesions were asymptomatic with no pruritus or photosensitivity, except for a few fresh lesions that were tender to the touch. This presentation could not be explained by any known dermatological condition, according to our dermatology colleagues, which made us suspicious. She got admitted in our indoor department. On detailed dermatological survey, these lesions were noted to be located on the easily approachable aspect of bilateral upper limbs and legs, with sparing of the

usually covered and unapproachable areas of limbs, trunk, and genitalia. She denied any knowledge of the origin, cause, or circumstances in which these skin lesions appeared or progressed, of course she did not admit their self-infliction. There was no scalp lesion or loss of hair. Ear lobe, natal cleft, umbilicus and nails were also normal.

Routine blood tests, including complete haemogram, urea/creatinine and liver function test were normal. Blood for anti-nuclear factor (ANF) was positive in 1:40 dilution only. A biopsy from the skin lesion (fresh) revealed only non-specific inflammation without any immune deposits. The biopsy specimen was also negative for AFB.

On psychiatric analysis, it was found that she had depressed mood, loss of interest and enjoyment, reduced concentration, pessimistic views about future, reduced self esteem and self-confidence with occasional suicidal ideation. According to her father, these were continuing for last six months. The patient was the youngest of four siblings, having disturbed interpersonal relationships. MSE revealed alert, cooperative patient having poor eye contact, stooped posture, semi-abstract thinking and with depressed, constricted affect which was decreased in range and reactivity. There was slow, soft, monotonous speech with increased reaction time. Preoccupied thought and suicidal ideation were present, but there was a normal cognitive function and grade 4 insights.

After multiple sessions of the interview, the interviewer was able to establish rapport. The patient confessed having significant stress due to the prevailing family situation and that she had inflicted the wounds with her nails. During her stay in the wards, she was once observed unawares by a nurse scratching her face vigorously.

Fig 1: Facial lesions over cheek and forehead

She was prescribed Fluoxetine 20 mg OD and also associated supportive psychotherapy. After two weeks the old lesions crusted with minimal inflammation and some hypopigmentation (Fig 2). After one month of medication and intense supportive psychotherapy appearance of new lesions stopped completely. She is now on regular following up under both psychiatry and dermatology consultants. The depressed mood has now improved to some extent

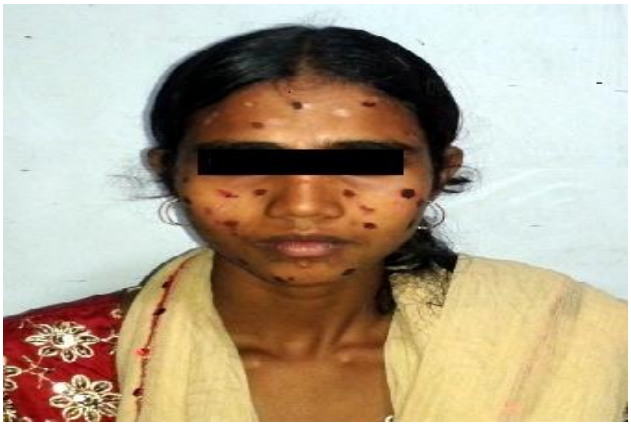

Fig 2: partially healed facial lesions after starting of treatment

DISCUSSION

Dermatitis artefacta (DA) is an under diagnosed skin condition.[1, 2] These patients may have various psychiatric disorders with long history of hospital attendance or they may report absolutely normal health with no underlying stress factors.[2] History of substance abuse or family history of psychiatric illness must be enquired in suspected cases of DA. Our patient did not have any substance abuse, but she later reported personal conflicts. However, the main obstacle for diagnosis is the low index of suspicion among clinicians. Since these patients may present to any speciality, all clinicians must be aware of this entity. In our case, the patient first visited a general physician where she was prescribed antibiotics and local steroids for one week. Females are reported to be more affected by this disorder with highest incidence in the second decade of life.[1] In some cases, borderline personality disorder is found to be the underlying psychiatric comorbidity.[1] Other disorders reported to be associated with DA include post traumatic stress disorder, multiple personality disorder and anorexia nervosa.[3] Especially in eating disorders, the prevalence of DA was found to be as high as 33% in one study.[3]

The lesions of DA are usually present in accessible parts of the body like face, distal upper and lower limbs or front of chest.[2] The lesions may vary from superficial erosions to deep ulcers, necrosis, scars and even crusted linear lesions or ecchymoses. Post inflammatory hypopigmentation, like our case, is very common. Two other common associations with DA are monalisa smile and hollow history.[3] Hollow history means the patient will deny any knowledge of temporal profile or evolution of the lesions, as in our case. Mona lisa smile means the patient will have an indifferent attitude towards the seemingly serious skin lesions although the relatives will be highly agitated.[4] The diagnosis often comes as a shock and patients and relatives will often vigorously deny the etiology.[4] The patients do not do this for economic gain or some other ulterior motive but just as an outlet to pent up stress.[4] Thus, only treatment of the skin lesions will not help the situation, proper sympathetic understanding and rapport is needed.

DA falls in the broad group of psychocutaneous disorders. This includes disorders like trichotillomania, delusion of parasitosis or neurotic excoriations.[5] Often, differentiation can be very difficult. Especially neurotic excoriations (NE) may often be confused with DA. But in NE, there is usually a benign skin lesion which is repeatedly picked with crusting. Scrotum or perianal regions are often preferred.[5]

The skin lesions in DA may be caused by nail scratching, as in our case, or with more harmful substances like cigarette butt, caustic chemicals or by binding elastic rubber bands.[6] Hence, meticulous examination of the skin lesions is needed. Also, the wounds may get secondarily infected even with organisms like pseudomonas.[4] Thus, proper counselling of the patients is needed and patients may often need admission for a period to avoid self-harm.[1, 4] Sometimes, skin vasculitic lesions may closely mimic DA. Both occur commonly in females of roughly the same age.[6] Thus, in equivocal cases, skin biopsy must be done. Persons with Munchausen syndrome also inflict same type of skin lesions.[6] But proper psychoanalysis will reveal the underlying deliberate motive of some gain. While DA is a psychiatric disease and needs compassionate therapy, Munchausen syndrome is basically a criminal behaviour.[6]

DA has been rarely reported from India. However, as the general awareness among clinicians is rising, this disease is being diagnosed with more frequency.[7] The social or familial factors leading to DA are unique to India and thus, needs individualised approach.

Finally, it should be remembered that DA is not just a psychiatric disorder. It is often a subtle ‘cry for help’. This diagnosis may be an opportunity to address the underlying mental conflicts of a person and resolve the issues. Thus we can avoid future catastrophe like suicide. But cases must be handled with extreme care as patients often react violently when confronted with the diagnosis. We present this case to sensitize the clinicians to this diagnosis.

CONCLUSION

Dermatitis artefacta is a rare psychiatric disorder which may present to any speciality. Proper diagnosis and sympathetic counselling are the cornerstones of management. One should always try to address the underlying psychological problems.

Conflict of interest: none
Consent of patient: taken

REFERENCES

1. Koblenzer CS. Dermatitis artefacta. Clinical features and approaches to treatment. Am J Clin Dermatol. 2000;1:47-55
2. Koo JY. Dermatitis Artefacta. Medscape. Available online from http://emedicine. medscape.com/article/ 1121933-overview
3. Gattu S, Rashid RM, Khachemoune A. Self-induced Skin Lesions: A Review of Dermatitis Artefacta Cutis. 2009;84:247-51
4. Obasi OE, Naguib M. Dermatitis artefacta: a review of 14 cases. Annals of Saudi Medicine 1999; 19:223-26
5. Jafferany M. Psychodermatology: A Guide to Understanding Common Psychocutaneous Disorders. Prim Care Companion J Clin Psychiatry. 2007; 9 :203–13
6. Wong JW, Nguyen TV, Koo JYM. Primary Psychiatric Conditions: Dermatitis Artefacta, Trichotillomania and Neurotic Excoriations. Indian J Dermatol. 2013; 58: 44–48
7. Kumaresan M, Rai R, Raj A. Dermatitis artefacta. Indian Dermatol Online J. 2012; 3: 141-43.