SkIndia Quiz 15

Hyperpigmented and purpuric plaques on trunk

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A 50-year-old male, a driver by occupation, presented with complaints of recurrent itchy dark colored lesions over body since past 6 months. Initially, he noticed a few dark colored lesions over trunk, which then spread to involve his buttocks and extremities over a period of next 15 days. The individual lesions would develop as scaling in a duration of 3 days and subsequently would heal leaving a dark spot. The lesions were associated with mild oozing of clear fluid. He was a former alcoholic who had been abstaining for the past 15 years with a few intermittent alcoholic binges in the past two months. He gave history that his son also had similar lesions over face, which healed with dark colored pigmentation. General physical and systemic examination was essentially within normal limits.

Dermatological examination revealed multiple, well-defined, discrete hyperpigmented to purpuric plaques distributed symmetrically over face, neck, trunk, bilateral extremities, and buttocks [Figures 1 and 2]. Few of the lesions on the buttocks were eroded.

Histopathology of the skin lesions revealed subcorneal clefting. Necrotic keratinocytes with lymphocytes were present in the clefts. Spongiosis was present in underlying dermis, with vacuolation and subepidermal clefting at places. There was a clumped lymphocytic infiltrate at few places in the dermis, especially around appendages [Figure 3].

WHAT IS THE DIAGNOSIS?

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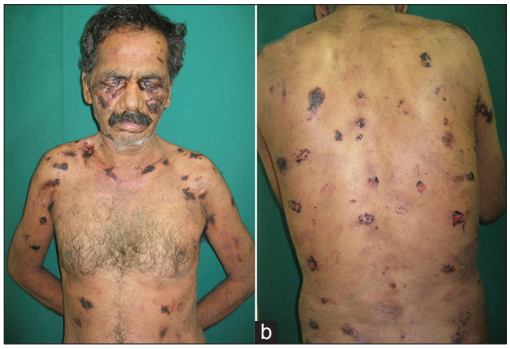

Figure 1: (a and b) Bilaterally symmetrical purpuric plaques on trunk and face

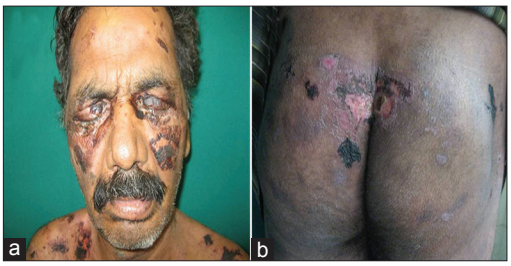

Figure 2: (a) Purpuric plaques on eyelids. (b) Purpuric plaques with erosions on buttocks

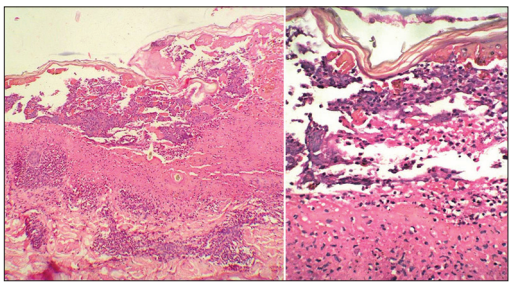

Figure 3: Histopathology revealing subcorneal clefting along with necrotic keratinocytes and lymphocytes in the clefts. Spongiosis was present in underlying dermis, with vacuolation and subepidermal clefting at places. There was a clumped lymphocytic infiltrate at few places in the dermis, especially around appendages (H and E, ×40)

ANSWER

Dermatitis artefacta.

DISCUSSION

This patient had skin lesions resembling primary systemic amyloidosis and generalized fixed drug reaction. The patient was investigated thoroughly for the same. Skin biopsy findings along with negative Congo red stain ruled out these differential diagnosis. There were few refractile spots in the histopathology section, indicating foreign bodies. With the bizarre history and examination and histopathology findings, a diagnosis of dermatitis artefacta was considered and a psychiatric consult was sought. He was found to have inappropriate affect and psychometric evaluation revealed features of depression, denial, and weakness in coping strategies. He confessed to self-inflicting the injuries after prolonged psychiatric evaluation. The patient gave history that he used various plant material and seeds to inflict the injuries as he felt they would not harm him and would relieve him of all his mind problems. The main culprit was identified as Semecarpus anacardium or a marking nut, which was present in his neighborhood. The history that his son had similar complaints was also proved to be made up by the patient. Psychotherapy in the form of tab Escitalopram 40 mg OD and repeated counseling is presently being administered with satisfactory results.

Dermatitis artefacta is a psycho-cutaneous disease resulting from patient's own actions, i.e., self-inflicting injury on his skin. The incidence of factitious disorders or dermatitis artefacta is estimated to be 0.05-0.5% of all dermatological cases.[1] Most studies have shown female preponderance with ratio of female to male ranging from 20:1 to 4:1.[2]

Various types of psycho-social conflicts and other unconscious motivating factors are implicated in this self-destructive activity.[3] Cutaneous lesions are polymorphic, bizarre, and can mimic any known inflammatory or infective conditions. The lesions are usually crude, angulated, linear, and may occur due to thermal, chemical, or instrumental injury. Lesions mimicking pyoderma gangrenosum, syphilis, Wegener's granulomatosis, Behcet's, and many others have been described in the literature.[4]

Histopathological features are usually non-specific, with certain features like necrosis, polymorphonuclear infiltrate, and erythrocyte exocytosis being reported most often.[5] Our patient had all these features along with subcorneal clefts and evidence of some foreign bodies in the dermis. Management of these patients includes a gentle and non-confrontational approach by building a mutual trust with them.[6] Follow-up is essential as these patients have an unpredictable prognosis.

The patient was unique in the fact that there were bilaterally symmetrical lesions even in inaccessible sites and lesions, mimicking amyloidosis, that have not been mentioned previously. Hence, whenever there is no clinicopathological correlation in patients presenting with bizarre skin lesions, a diagnosis of dermatitis artefacta should be considered.

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