Dermatitis artefacta

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ABSTRACT

Dermatitis artefacta (DA) is a psychocutaneous disorder where the skin lesions are self self-induced to satisfy an unconscious psychological or emotional need. We report a case of DA where we video recorded the patient self-inducing the lesions.

Key words: Dermatitis artefacta, psychocutaneous, factitious

INTRODUCTION

Dermatitis artefacta (DA) is a factitious dermatological disorder with many forms of presentation that may involve any part of the body. In women, it is regarded as a "cry for help'', especially when the patient is faced with psychosocial stress. A high index of suspicion is required to diagnose the condition as the history is often vague as patients dissociate while they self-abuse.[1] Herein, we report a case of DA.

CASE REPORT

A 11-year year-old boy presented to us with multiple linear excoriations and erosions on the forearm, leg, face and dorsum of the hand of 11 months duration. The child and the parent were unable to explain the evolution of lesions. He gave a history of sudden onset of the erosions over the body. Lesions disappeared with post inflammatory pigmentation within 10 days. There was no pain or itching over the lesions. He was evaluated in many hospitals for dermatitis and investigated extensively. On examination, there were multiple, linear, well well-defined excoriations and erosions with crusting and scab formation of varying sizes over the forearm, face, legs and dorsa of the hands [Figures 1 and 2]. Lesions were more frequent on the left side of the body. Only the accessible parts of the body were involved and inaccessible parts such as the midline of the back were spared. Routine hematological and biochemical investigations were within normal limits. Histopathology of the skin lesions was non-specific. With the above history and the clinical findings, we made a provisional diagnosis of DA. The child was admitted in the ward and was put under close circuit camera surveillance without his knowledge. Video recording showed the child picking on his skin and presenting with erosions and excoriations. Video recording was shown to the parents to convince them about the diagnosis. On careful history and multiple sessions of counselling with the help of a psychiatrist, the child confessed to self-inducing the lesions. The reason behind his act was the parental attention being given to his elder sister, and he tried to draw attention by self-inducing the skin lesions. Detailed psychiatric evaluation was done and the child was advised counselling without any medications, following which he improved. He was followed up for a period of 6 months without any recurrence.

DISCUSSION

DA is a psychocutaneous disorder where the patient self-inflicts to create skin lesions to satisfy the internal psychological or emotional need. Patients intentionally create lesions to assume the sick role and typically deny the self-inflicted nature of the injury.[2] Patients frequently have an impulsive personality disorder.[3] 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.[3]

Skin lesions are always self self-inflicted and the morphology varies widely depending on the

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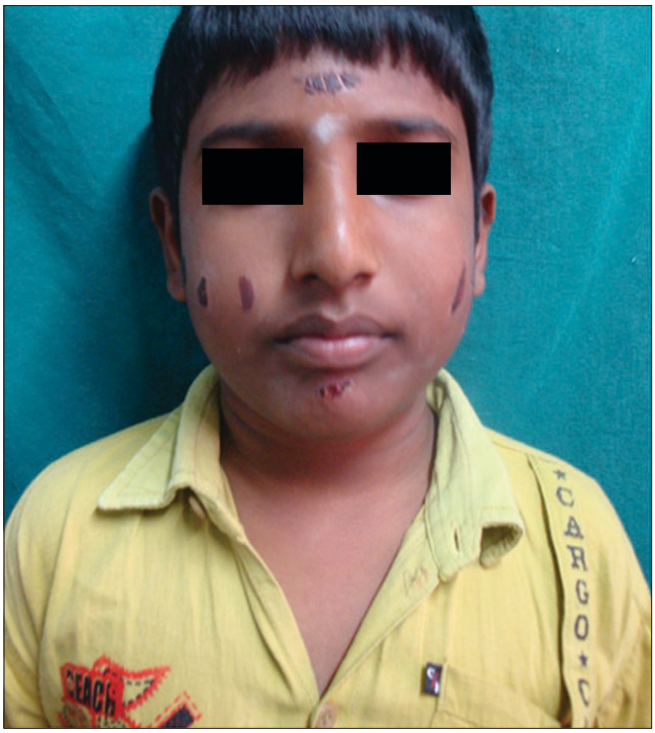

Figure 1: Linear erosions over the face

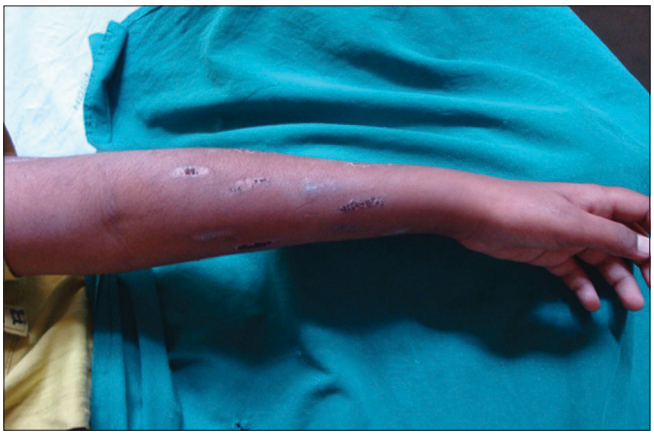

Figure 2: Multiple, linear, healed erosions over the forearm

mode of injury: cutting, abrasion, burning, applying chemicals, and injecting various products. Bizarre lesions with sharp geometric borders surrounded by normal skin is characteristic of DA.[4] The various methods of producing the skin lesions are highly imaginative and depend on the patient's background and education.[5] Lesions may be produced by a variety of mechanical or chemical means, including fingernails, sharp or blunt objects, burning cigarettes and caustic chemicals.[5] 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,[6] as in our case. Recurrent excoriation produces inflammation and lichenification of the skin; the resultant irritation and pruritus leads to further self self-trauma and chronic dermatitis.[3] Patients are unable to explain the evolution of these lesions, since they dissociate themselves while self-inflicting. Indifference to symptoms is also commonly encountered. Precipitating factors for DA range from simple anxiety to severe personality disorders, including attention-seeking traits, obsessions, compulsions, depression and psychotic disturbances.[5] 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.[7]

This diversity makes it particularly difficult to diagnose DA. Except in mild transient cases triggered by an immediate stress, the prognosis for cure is poor.[5] The condition tends to wax and wane with the psychosocial circumstances of the patient's life.[8] Long-standing cases may be secondary to underlying anxiety or depression, emotional deprivation, an unstable body image or a personality disorder with borderline features.[5] Many use their lesions to obtain attention, maintain contact with others and fill their emotional emptiness.[9] The visible skin lesions can be understood as an attempt at non-verbal communication subserving an appeal function.[9]

Patients with DA are particularly sensitive when confronted by medical practitioners, to which they react with renewed self-mutilation.[10] The condition must be distinguished from neurotic excoriations and Munchausen's syndrome, as the psychopathology, and therefore the treatment, is different in each case.[11] Patients with neurotic excoriations usually have depression or anxiety with obsessive-compulsive features; those with Munchausen's syndrome have a sociopathic personality, while patients with dermatitis DA are most commonly diagnosed with the borderline personality disorder.[11] 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 self-mutilation.[3] 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.[3]

Psychotropic medication, including antipsychotics, might be helpful in certain clinical situations, but is unnecessary for all cases.[1] The antipsychotics like pimozide, aripiprazole and risperidone are the drugs of choice, and aripiprazole has an advantage in that it also has antidepressant properties. Appropriate referral to other community resources with expertise in assisting patients who self-abuse, including self-help groups available in some communities is an important adjunct to treating these skin lesions.

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