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A near fatal case of pathological skin picking

Department of Medicine, Riverside County Regional Medical Center, Loma Linda
University School of Medicine, Moreno Valley, CA, U.S.A.

Authors' Contribution:
Study Design A
Data Collection B
Statistical Analysis C
Data Interpretation D
Manuscript Preparation E
Literature Search F
Funds Collection G

ABCDEF **Daniel I. Kim**
ABCDEF **Roger C. Garrison**
ABCDEF **Gary Thompson**

Corresponding Author: Daniel I. Kim, e-mail: daikim@llu.edu

Patient: Female, 51
Final Diagnosis: Pathological skin picking
Symptoms: Aphasia • headache • hemiparesis • incontinence
Medication: —
Clinical Procedure: —
Specialty: Dermatology

Objective: Challenging differential diagnosis





Background: Pathological skin picking (PSP) disorder is characterized by repetitive and compulsive picking of the skin resulting in tissue damage. PSP has been shown to affect 5.4% of a community sample, 4% of college students, and 2% of patients seen in a dermatology clinic. It can be associated with significant disfigurement. The diagnosis requires obtaining a careful history and high clinical suspicion.

Case Report: We report a previously healthy 51-year-old Caucasian female with a history of “acne” who presented with new onset right-sided hemiparesis, mild aphasia and an episode of incontinence. She had memory loss of the prior few days. She also complained of a four-day history of intense headaches and dizziness. CT and MRI of the head showed encephalomalacia involving the left frontal and parietal lobes. Further history from the patient revealed that the patient had been picking at her forehead with a sewing needle and later with a long knitting needle.

Conclusions: PSP is a prevalent disorder, which can have potentially serious health consequences. Besides potential disfigurement and scarring, PSP can have significant morbidity and mortality. Early diagnosis and appropriate treatment by clinicians are essential to prevent potentially fatal consequences.

Key words: pathologic skin picking • impulse control disorder

Full-text PDF: <http://www.amjcaserep.com/download/index/idArt/889357>

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Background

Pathological skin picking (PSP) disorder is characterized by repetitive and compulsive picking of the skin resulting in tissue damage [1,2]. It has been shown to affect 5.4% of a community sample, 4% of college students, and 2% of patients seen in a dermatology clinic [3,4]. There is also a high prevalence of PSP among individuals with obsessive compulsive disorder (OCD) and body dysmorphic disorder with a lifetime incidence of 10.4% and 44.9%, respectively [5,6].

Case Report

A previously healthy 51-year-old Caucasian female with a history of “acne” presented with new onset right-sided hemiparesis. In November, the patient started to pick at “acne” on her face and forehead. For the next couple of months, she repeatedly picked at three separate lesions on her forehead until they formed one large ulcer. She later wore a piece of gauze on her forehead to conceal the wound from her family, as she continued picking at the wound with a needle in private.

In February, the patient was brought to the Emergency Department by a neighbor for evaluation of a possible stroke. She presented with right-sided hemiparesis, mild aphasia and a reported episode of incontinence. She had memory loss of the prior few days. She also complained of a four-day history of intense headaches and dizziness. Family history was non-contributory. She denied any previous psychiatric history, or history of drug or alcohol abuse.

On admission, the patient’s vital signs were normal. The physical exam was notable for right upper and lower extremity hemiparesis (with 3+/5 strength). A gauze dressing was located on patient’s forehead just below the hairline. Upon removal of the dressing, the patient had a 4×2 cm wound that extended through all dermal layers of her scalp, with exposure of the cranium. The sagittal suture was clearly visible, as well as a 4 mm skull defect in the left frontal bone. The patient also had two large healed facial scars.

A computerized tomography (CT) scan of the head showed a defect in the left frontal bone and overlying scalp with significant encephalomalacia of the left frontal lobe (Figure 1). There was no obvious evidence of ischemic infarcts. A brain magnetic resonance imaging (MRI) scan revealed encephalomalacia involving the left frontal and parietal lobes (Figures 2 and 3). The distribution was noted to be in a very unusual pattern, as the area of encephalomalacia appeared to track directly to the patient’s open frontal scalp wound.

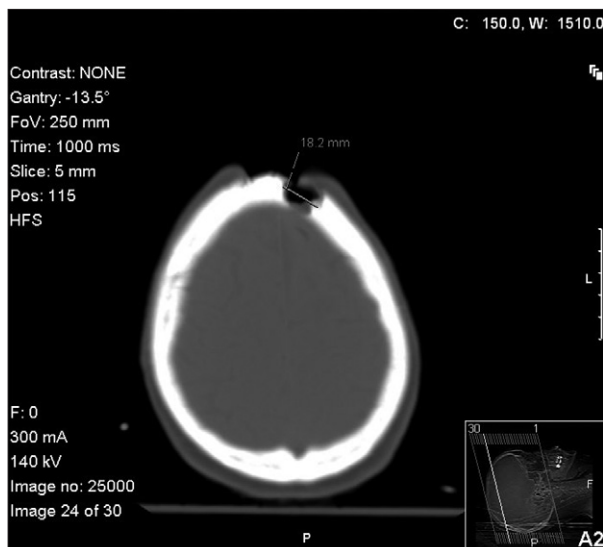


Figure 1. CT head (bone view) – 18.2 mm Left frontal bone skull defect.

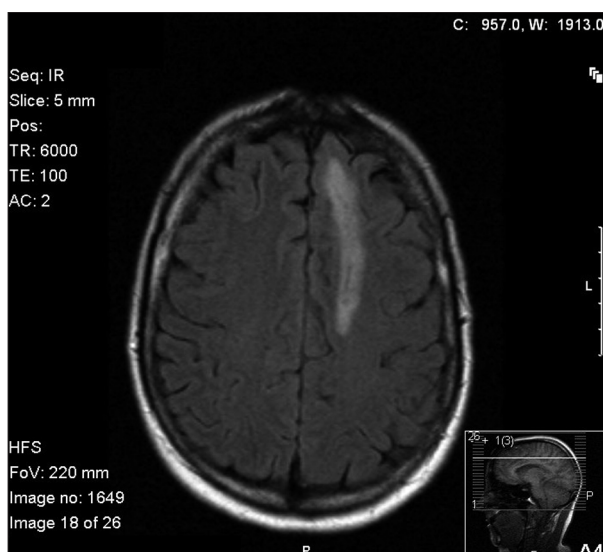


Figure 2. MRI head – encephalomalacia of left frontal lobe.

A neurosurgery consultation was obtained due to the concern for a possible intracranial infection. After evaluating the patient, it was determined the patient would only require a superficial debridement of the scalp, and not require a craniotomy. After the debridement, the patient was treated with intravenous antibiotics.

Upon obtaining further history, the patient admitted to picking at the “acne” on her forehead with a sewing needle and then more recently a long knitting needle. She reported that she felt compelled to pick at these lesions because they “bothered” her and that she could not stop despite knowing she was making the skin lesions worse. After psychiatric evaluation, the patient was diagnosed with Obsessive Compulsive Disorder and was started on fluoxetine.

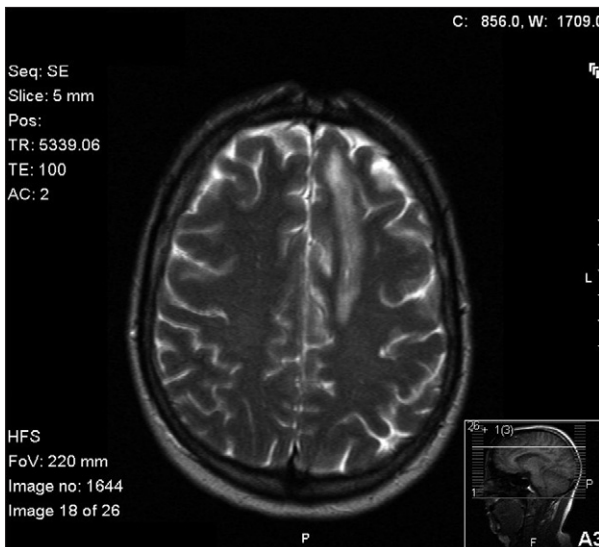


Figure 3. MRI brain – frontal bone defect immediately to the left of midline along with a defect in the adjacent scalp. There is focal encephalomalacia in the left frontal lobe in a parafalcine location.

After recovering from surgery and completing a course of antibiotic therapy, the patient's condition stabilized. She was subsequently transferred to an inpatient psychiatric facility for ongoing psychiatric evaluation and treatment.

Discussion

PSP lacks its own diagnostic category or criteria in the *Diagnosics and Statistical Manual of Mental Disorder, Fourth Edition, Text Revision (DSM-IV-TR)*, but is considered an impulse control disorders not elsewhere classified, along with trichotillomania, kleptomania, pyromania, pathologic gambling, and explosive disorder [2]. However, since the development of DSM-IV over a decade ago, ongoing research and scientific developments have resulted in efforts to include PSP into the DSM-V as an autonomous category with defined diagnostic criteria [2].

As reported in recent studies, most patients with PSP exhibit typical demographic and clinical features. The majority of patients are women, with onset usually during adolescence to late 30's [7]. Our case was a little unusual since our patient presented in her sixth decade. However, we suspect the patient's condition was chronic and had been present for many years without diagnosis. Many patients with PSP delay seeking treatment because they often feel embarrassed by and ashamed of their behavior, and are unaware that effective interventions exist [2,4,8]. Skin picking is often not a transient behavior but may persist with a waxing and waning lifetime course [3].

PSP usually begins with a dermatologic condition, such as acne in our case, and patients are often referred to clinicians other than psychiatrists for medical complications such as dermatologists or surgeons [3]. The most common picking sites are the head and face, and although most patients pick with their fingernails, a minority of patients will use tweezers or other objects [3,4]. Our patient used needles to pick at her face and eventually used a knitting needle that was over 22 centimeters long.

It is imperative that the primary care physician, psychiatrist, dermatologist, or emergency room physician thoroughly investigate the source of all superficial skin ulcerations. A thorough medical and psychiatric history should be obtained. The physical examination should include a detailed dermatologic exam to assess the extent of the wound and to evaluate for primary pruritic skin disorders such as scabies, psoriasis, atopic dermatitis or other chronic pruritic skin disorders associated with nutritional deficiencies or malignancy. Any case shown to be a result of a self-inflicted disorder must be referred to a psychiatrist in order to be fully evaluated. Psychotherapy and pharmacotherapy treatment should be considered to avoid possible serious outcomes.

While selective serotonin reuptake inhibitor (SSRI) antidepressants have been shown to be efficacious in the treatment of obsessive-compulsive disorder [9], there have been fewer clinical trials evaluating the role of SSRI's for the treatment of PSP. These clinical trials have been limited by small sample sizes and many have utilized open-label study designs. Small double blinded studies have demonstrated the superiority of fluoxetine over placebo in the treatment of PSP [10,11]. Small clinical trials have demonstrated decreased skin picking severity, improved general health status and quality of life with SSRI's [12,13]. Cognitive and behavioral therapies may be beneficial as primary treatments or as adjunctive therapy along with SSRI's [8,14].

Conclusions

PSP is a prevalent disorder, which can have potentially serious health consequences. Our case demonstrates that patients with repetitive facial picking may develop wounds that could lead to fatal consequences from direct brain injury or intracranial infection. This case has highlighted the need for awareness of pathologic skin picking when evaluating skin lesions. All patients with PSP should be referred for psychiatric evaluation. Treatment with SSRI's and cognitive-behavioral therapy may provide significant benefits to these patients and reduce the likelihood of catastrophic complications from this disorder.

Statement

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