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Dermatitis Artefacta

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ABSTRACT

Dermatitis artefacta, also known as factitial dermatitis, is a disease in which self-inflicted skin injury is utilized to fulfill a conscious or unconscious urge to play the sick part. It is more frequent in women and individuals who have an underlying mental illness or are under external stress. The diagnosis is one of exclusion, and it is sometimes difficult to establish since patients seldom acknowledge to playing a part in the development of their lesions. Treatment can be difficult, and treatment should rely on a multidisciplinary team comprised of dermatology and psychiatrist.

1. Introduction

Dermatitis artefacta (DA), also known as factitial dermatitis, is a disease in which self-inflicted skin injury is utilized to satisfy a conscious or unconscious urge to take on the role of a sick person. Malingering, in which skin injury is done for the goal of secondary benefit, should be differentiated from DA.¹

Due to a lack of identification and diagnostic difficulties, DA is more prevalent than documented, with patients seldom confessing their participation in the development of the cutaneous lesions. It is more common in women, individuals in their early adulthood, and those with an underlying mental illness or external stress, and has been noticed often among healthcare workers. Borderline personality disorder, dependence, and manipulative behavior are all common psychiatric findings. Furthermore, an

effect incongruent with the intensity of the presentation is frequently noted.^{1,2}

Clinical manifestation

Dermatitis artefacta has been recognized by dermatologists since classical time. The atmosphere is tense as the young woman sits, dramatic lesions flagrantly exposed, waiting with calm manner and friendly smile to greet the physician. By contrast, the accompanying family member(s) wait anxiously, and with suspicion, eager to discuss the thick medical file, replete with myriad and oft repeated studies, that they have brought to the consultation, demanding verbally, and with every body movement, that one understand the family's anger and disappointment with those (often many) of one's colleagues who have previously

been consulted.^{2,3}

A similar tableau can be observed in dermatitis artefacta by proxy. Morphologically, the lesions themselves are as variable as the creativity of their perpetrators, and the methods employed, will allow.^{2,3,4} Certain features, however, are shared in common. Except in situations where a known dermatosis is perpetuated or mimicked lesions do not have the recognizable characteristics of a known dermatosis. Margins are sharp, clearly demarcated from adjacent normal skin, and borders are angulated and geometric, while the surface, whether crusted and necrotic, abraded or atrophic, may indicate the idiosyncratic pathways exploited by the creator's hand. Where corrosive liquids have been used, the characteristic linear tracks can be traced on the skin. Common sites are the face, upper trunk, and extremities; whether single or multiple, all are within reach of the hands. In a right-handed person, the left side is usually involved, and the accessible body parts are usually more involved than inaccessible parts like the midline of the dorsum.^{2,3,4} Recurrent excoriation produces inflammation and lichenification of the skin, resulting in irritation and pruritus, which leads to further self-trauma and chronic dermatitis.²

Types of lesions seen in dermatitis artefacta abrasions or erosions, alopecia, crusted lesions, discolored macules, erythematous papules, excoriations, nail deformity, petechiae or purpura, scars in chronic cases, ulcerations.⁴

Creative patients may sometimes produce lesions that exactly mimic those of a prior dermatosis, now resolved, or, identifying with a family member, friend or acquaintance, an exact facsimile of the other person's lesions may mysteriously appear. In some cases, lesions will obligingly appear at a site suggested by another as susceptible. To inability to elicit evidence of evolutionary changes has been termed the holistic low history and is very characteristic of dermatitis artefacta.^{4,5,6}

Diagnosis

Skin changes may be the result of various types of

damage: mechanical, chemical, thermal, and even electrical, including fingernails, sharp or blunt objects, burning cigarettes, and caustic chemicals. Precipitating factors for DA range from simple anxiety to severe personality disorders, including attention-seeking traits, obsessions, compulsions, and psychotic disturbances. Long-standing cases may be secondary to underlying anxiety or depression, emotional deprivation, an unstable body image, or a personality disorder with borderline features.^{5,6}

Histopathological features are non-specific, as our biopsy revealed. Usually, it has characteristics of acute but mild inflammation with increased polymorphonuclear leucocytes and scattered erythrocytes. Areas of necrosis with areas of healing and fibrocystic reaction may also occur.¹ The condition must be distinguished from neurotic excoriations and Munchausen's syndrome because the psychopathology, and therefore the treatment, is different in each case. Patients with neurotic excoriations usually have psychiatric comorbidities. The most common comorbidities related to DA are obsessive-compulsive disorder (15–68%), depression (42%), and alcohol abuse/dependence (40%), while those with Munchausen's syndrome are sociopathic personalities.^{6,7}

According to the latest update of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), diagnostic criteria of DA are based on: 8 recurrent skin picking resulting in skin lesions, repeated attempts to decrease or stop skin picking, the skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, the skin picking is not attributable to the physiological effect of a substance or another medical condition, and the skin picking is not better explained by symptoms of another mental disorder.

Psychogenic purpura, also known as Gardner-Diamond syndrome or auto-erythrocyte sensitization syndrome, is a rare condition characterized by the spontaneous, unexplained, painful bruising mainly seen on the extremities and trunk but can occur anywhere on the body. Severe stress and emotional

trauma usually pre-cedes the skin lesions. Women are commonly affected, but isolated cases have been reported in adolescents and in males.⁸

Pathophysiology

Psychological stress has been associated with the onset or exacerbation of a wide range of cutaneous disorders. In the literature, the term, 'stress,' is used to address the sequel of major catastrophes in the lives of individuals.^{1,2} These include natural or accidental events such as major earthquakes or life-threatening accidents. Psychological stress focuses on patients' subjective evaluations of their capacity to cope with life circumstances (e.g. the stress induced by the social stigma of having a skin disorder or the unexpected death of a loved one). Physical trauma represents a more severe form of stress. Such events include war, torture, concentration camp experiences, severe accidents or illness, child abuse, rape, violence in the family, and personal assault/physical abuse.^{1,4,8}

Biological factors, such as stress-induced activation of the hypothalamic-pituitary-adrenal axis commonly found in depression, likely have an important role given that skin disorders are more prevalent in depressed individuals. Due to difficulties in insight and body image, DA has been compared with anorexia nervosa as it often coexists with this condition.⁷ DA patients tend to have introverted personalities, self-centered attitudes, and emotional immaturity. Subsequently, adults may respond to stressful circumstances in an impulsive manner, due to an immature personality style. These patients experience difficulty when stressed and their discomfort is further aggravated because of poor communication skills.⁸ A background of emotional disturbance has been noted to be present during formative years, leading to feelings of insecurity and isolation in later life. The onset of DA has been closely associated with the psychological stress of a major life event. The visible lesions represent an attempt at nonverbal communication which is similar to an appeal.⁶

Patients with the factitious disorder usually have

an affinity with the medical system and have maladaptive coping skills.^{2,4} This behavior often occurs in the setting of a loss such as the death of a relative or an occupational loss. Securing the attention of family, friends, and medical professionals is likely a way of obtaining emotional solace. There is a motivation to assume the sick role, which initially evolves within the family and then with health care providers. Behavioral theories postulate that in early life these individuals received a reinforcement of the sick role. Patients can have self-hate and guilt, and an illness that allows inappropriate regression and avoidance of adult responsibilities.^{5,8} The psychological trauma of sexual abuse has been reported to precipitate DA. Factitious illness can also symbolize anger and conflict with authority figures (school phobia being a case in point). They usually experience emotional deprivation during childhood, resulting in an unstable body image, and a need to be cared for.

Children and adolescents often develop anxiety and immaturity of coping styles in response to a dysfunctional parent-child relationship (e.g. rejecting mother, absent father), bullying, physical changes in the body and substance use.^{5,6} The sensation of self-induced pain and physical lesions may relieve their isolation and distress, and even help them establish a sense of identity. Chronically affected patients generally have comorbid personality disorders, especially borderline and hysterical in women and paranoid personality disorder in men.⁸ DA was observed to provide temporary relief from symptoms such as racing thoughts, depersonalization, and marked anxiety. Association with an eating disorder and substance abuse was noted in this series as well. DA has been associated with a dissociative identity disorder.

Treatment

Psychocutaneous disorders are optimally managed when the dermatologist and psychiatrist collaborate in the patient's management, although treatment can be very challenging. Referral to either psychiatry or a

multispecialty clinic would be appropriate. These patients are often very reluctant to accept a referral to psychiatry. The treatment of DA consists of the doctor-patient relationship, and topical and systemic treatments. A supportive, trusting, nonjudgmental relationship is needed for any type of treatment to succeed.^{1,2,8}

A detailed assessment of the patient's history for chronic dermatoses, chronic medical conditions, psychiatric illnesses, and psychosocial problems is necessary. General dermatologic care measures include baths, debridement, emollients, and topical antimicrobials. The use of occlusive dressings can permit healing.^{3,8}

Analgesics should be avoided because of the high probability of dependence. Systemic treatment can be dermatologic and psychiatric. Oral antibiotics and antifungal agents are prescribed as needed based on culture and laboratory findings, as are antihistamines (for pruritus) and appropriate supplements (i.e., iron or B-12. Anxiety is common and can be addressed with one of the selective serotonin reuptake inhibitors (SSRIs), or with anxiolytics such as buspirone or benzodiazepines. SSRIs are considered first-line therapy for depression, and are usually prescribed in higher doses for compulsive and self-injurious behaviors.⁸

A tricyclic antidepressant (TCA) with antihistamine, antipruritic and antidepressant properties (doxepin) is recommended for depression with or without agitation and with pruritus as the primary symptom. A TCA with analgesic properties (amitriptyline) is appropriate for depression with pain sensations (e.g. burning, or stinging) as the primary symptom. Low dose typical (pimozide) and atypical antipsychotics (olanzapine, aripiprazole, risperidone, quetiapine) may be considered for short-term use, particularly if skin lesions are associated with psychotic or delusional symptoms.⁸ Nonpharmacologic, complementary adjuvant therapies can be considered. These may include acupuncture, cognitive behavioral therapy (aversion therapy, systemic desensitization, or operant

conditioning), biofeedback, aromatherapy and hypnosis.⁸

2. Conclusion

Dermatitis artefacta (DA), also known as factitial dermatitis, is a condition in which self-inflicted skin damage is used to satisfy a conscious or unconscious desire to play the role of a sick person. Dermatologists have known about dermatitis artefacta since antiquity. DA is a rare cutaneous condition that must be considered when the clinical presentation is atypical and investigations do not yield an alternate diagnosis. Patients may be consciously unaware of the signs they are eliciting and usually have a history of underlying stress or psychological disorder.

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