



Factitious Dermatitis Apropos of a Case

Jessica Magali Herrera Abarca^{1*}, Verónica Maritza Carrillo Sañay², Jhoanna Cristina Almeida Alvarado³, Darío Javier Guerrero Vaca⁴

^{1,2,3,4}Departamento de Medicina, Facultad de Salud Pública, Escuela superior Politécnica de Chimborazo (ESPOCH), Riobamba, Ecuador. código postal 060150

***Corresponding author:** Jessica Magali Herrera Abarca, Departamento de Medicina, Facultad de Salud Pública, Escuela superior Politécnica de Chimborazo (ESPOCH), Riobamba, Ecuador. código postal 060150, Email: magali.herrera@epoch.edu.ec

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ABSTRACT

Factitious Dermatitis is a dermatosis with a psychiatric link, with a greater predisposition in the female sex, it constitutes a challenge for the Dermatologist due to the Polymorphism of the lesions where the patient denies the responsibility he has in self-inflicting the lesions, the diagnosis is practically by exclusion and due to the association with the history of presenting a psychiatric or psychological affectation, to improve the patient's condition it is necessary to intervene in the treatment both for the skin lesions and for the underlying pathology of this dermatosis, which is the psychiatric disorder trying to restore the personality of the patient. Many times the referral to a psychiatrist is rejected by the patient and the doctor ends up changing, which will make it difficult to improve the skin condition. In this case presented, the patient understands her situation and entails a joint treatment having positive results in her health problem.

Keywords: *Factitious dermatitis, Dermatologist, Psychiatric, polymorphism*

INTRODUCTION

There are multiple classifications of skin diseases that have a psychiatric link (1-2) and in all of them the nosological location of factitious dermatitis is clear, which is always considered as a manifestation of a primary psychiatric disorder. Probably the most complete and exhaustive of those published to date of psychodermatological disorders (3),

The term Factitious Dermatitis (FD) has been reserved for a group of patients whose skin artifacts originate in a secret and mysterious way, denying the patient his responsibility in the appearance of them. In FD, the patient produces skin lesions to satisfy a psychological need, usually the desire to be treated medically (4).

Psychocutaneous disorders are sometimes a diagnostic challenge, and are difficult to treat (5). In factitious dermatitis, also known as artifact dermatitis or pathomimia, the skin is the target of self-inflicted damage. Patients intentionally produce injuries to assume the role of the patient, although they deny the nature of this disorder (6). There are two essential characteristics to define this disease among self-provoked dermatoses: firstly, the absence of a rational reason to explain it and, secondly, the patient's denial of his responsibility for the origin of the injuries.

Skin lesions can be caused by mechanical means or by the application of chemical or caustic irritants and their morphology is very varied, being able to be erythematous lesions, excoriations, ulcers, blisters, crusts, edema, etc.

The diagnosis is not easy, it should be suspected by the morphology of the lesions, with angled or geometric edges, very precise. The location is important, they are usually symmetrical and easily accessible to the hands; sometimes more abundant in the area of access to the dominant hand. "Outbreaks" of injuries in relation to their emotional situation.

Patients frequently present with hysterical personality traits in women and paranoid traits in men; as well as, disorders in family dynamics. They have a controlling attitude even with the doctor. Hostile attitude to questioning, and responses make it difficult to determine the chronology of injuries.

The treatment is one of the most complex in dermatology, since it is the psychiatric pathology

of the sick person, which must be cured; so it must be a joint work of both specialties. According to Consoli, treatment is based on three fundamental pillars: 1) restructuring the patient's personality; 2) psychiatric pharmacological treatment and 3) medical treatment of skin lesions (7).

The referral to the psychiatrist is rejected by the patient, who understands that his condition is cutaneous; sometimes leading him to a confrontation and rejection of the recommendation, which ends up changing doctors.

Timeline

A 39-year-old female patient with a significant pathological history of anxiety, depression and obsessive-compulsive disorder was treated with quetiapine 25 mg daily, Valium 5 mg daily, fluoxetine 20 mg daily. who 2 years ago presents dermatosis type crusty plaques and erosions in the face arms, legs and back, accompanied by pruritus, refers that as an apparent cause relates it to the nervousness that presents when it has anxiety crises, also refers to having an obsession with the cleanliness of your body, face and hands, tries to wash your face about 5 to 6 times a day and hands between 15 and 20 times a day, He bathes 4 times a day this has triggered a lot of itching and dryness throughout his body, additionally he does not use moisturizer or sunscreen, in recent months the itching is unbearable and by the consecutive scratching has produced many injuries until bleeding and crusting forms together with atrophic scars, he went 4 weeks ago to a pharmacy and was sent to take fluconazole a weekly tablet and put terbinafine 1% cream in the lesions, the picture worsens so he goes to the Dermatology service at the Cardiopiel Medical Specialties Center.

In Cardiopiel is Valued and polymorphic lesions are observed, cutaneous xerosis, the lesions are located in areas up to where the hand is reached to scratch, Emollient treatment is placed to improve the texture and hydration of the skin, in addition 20% urea is sent for hydration, magisterial formulation with clobetasol to use on the lesions 2 times a day for 1 month, antihistamine (Cetirizine 10 mg) 1 tablet every 12 hours, psychotherapeutic treatment in clinical psychology to control obsessive compulsive

disorder and thus avoid self-flagellation of lesions, KOH is sent and direct injuries.

Patient Information

The 39-year-old patient, divorced, born and resident in Riobamba, education (superior). With personal pathological history Anxiety, Depression and Obsessive Compulsive Disorder in treatment with Quetiapine 25 mg daily, Valium 5 mg daily, fluoxetine 20 mg daily. Does not refer important family history is not allergic to any medication or food.

Physical Exam

Blood pressure: 110/65 mmHg – Heart rate: 64 per minute – Respiratory rate: 16 per minute – WEIGHT: 67 Kg- Height: 1.54 cm.- BMI: 28

The patient lucid, conscious, oriented, feverish, hydrated

Skin: normothermic xerotic and with multiple polymorphic lesions (Description in Dermatological Examination).

Heart: R1- R2 normal, no murmurs auscultated,

Lungs: preserved vesicular murmur; abdomen: soft depressible, not painful on superficial palpation, nor deep, hydro-aerial noises present.

Extremities: symmetrical non-edema

Dermatological examination:

Cutaneous phototype III

Type of lesions: Polymorphic

Location: face, trunk and upper and lower extremities

Distribution: disseminated (where the patient scratches)



FIGURE 1-4: Dermal Lesions

Diagnostic Evaluation: Complementary Tests

KOH and Direct Skin: negative

Therapeutic Intervention

Topical emollient treatment: Emollient baths, moisturizing based on 20% urea cream

Master formula based on clobetasol 0.05% ointment: place on lesions 2 times a day for 1 month

Cetirizine 10 mg: take 1 tablet every 12 hours for 1 month

Psychotherapy: Clinical Psychology

Control in 1 month Dermatology

Continuous therapies with clinical psychology

Therapeutic Monitoring And Response

Total remission of lesions in 1 month, but remains in therapeutic control with clinical psychology. Emollient maintenance treatment is left.

DISCUSSION

Factitious diseases are those in which the patient creates a sign or symptom to satisfy a psychological need, which he does not realize (8). Patients who suffer from them often have associated psychiatric disorders, among which are: anxiety, depression, suicidal tendencies and personality disorders (9). Although the actual incidence of factitious dermatitis is unknown, it has been found to be more common in adolescent women and young adults (10). Although the psychopathology of artifact dermatitis is poorly

understood, multifactorial causes, such as genetics, psychosocial factors, and personal or family history of psychiatric disorders have been associated (11). Frequently, a family member is involved in the medical field and patients are often versed in medical terminology. Acute episodes of artifact dermatitis often represent a maladaptive response to a psychosocial stressor (12). Long-term cases are usually secondary to an underlying anxiety or depressive disorder, emotional deprivation, altered body image, or a personality disorder with borderline characteristics.⁶ The morphology of dermatosis can be as varied as the different methods used (objects or substances) to inflict the lesions, acquiring variegated forms, with irregular or linear edges, without any primary lesion being found. However, it highlights the fact that it acquires a peculiar disposition, since it is located in places easily accessible to the hands of the patient (13) who, in addition, refers to an unclear history where the lesions "appear" suddenly, without preceding signs or symptoms (14). In 2005, Nielsen et al. conducted a retrospective study in which they analyzed the symptoms, gender, age, and social relationships of 57 patients in whom the diagnosis of artifact dermatitis had been established. They observed that the diagnosis is 2.8 times more frequent in women than in men, with an average of 39 years of age; Skin lesions were multiple in 88% of patients (15). When it was suggested that the lesions were self-inflicted, two-thirds of patients denied involvement in the origin of dermatosis, and only one patient agreed to see a psychiatrist (16). Personality traits are the enduring patterns of behavior that an individual possesses to perceive and relate to the environment, and are exhibited in a wide range of social and personal contexts (17).

The treatment should be dermatological intervention to improve the patient's discomfort, but psychotherapeutic intervention is of vital importance for the patient to understand and accept her health problem, family support is of vital importance in order to control this dermatopsychological affectation (18-20).

CONCLUSION

The dermatitis that our patient presents is a challenge for the dermatologist since it presents polymorphic lesions without a clear pattern located in visible areas more commonly

generally evolve as destructive lesions so it is necessary to collect information from personal pathological history, once identified it is necessary to intervene with dermatological treatment to improve the lesions, and at the same time perform a psychological intervention to contain more injuries and that the patient understands her health problem.

Patient Perspective

The patient lived and lives an experience of great concern and anxiety since due to her basic pathology she must try to keep her obsession disorder controlled by the cleanliness of her body to prevent the lesions from appearing again, it is vital that she remains in psychotherapy. When she was discharged, she was very grateful to all her medical team.

Informed Consent

We have the informed consent of the patient to publish their clinical case.

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