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Dermatitis Artefacta

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Introduction

Dermatitis artefacta or factitious dermatitis is a psychocutaneous disorder in which the patients consciously create lesions in skin, hair, nail, or mucosae to satisfy a psychological need, attract attention, or evade responsibility. The patients usually hide the responsibility for their actions from their doctors. Dermatitis artefacta should enter the differential diagnosis of every chronic, puzzling, and recurrent dermatoses.[1][1][2]

Etiology

Unlike malingering, there is no direct benefit sought from induction of the skin lesions. The patient induces the lesions to satisfy an internal psychological need, which is often the need to be noticed or to receive care. Various psychosocial conflicts, emotional immaturity, unconscious motivations, and disturbed interpersonal relations have been implicated as the etiological factors.[3][4]

Epidemiology

In general, there is female preponderance (female-male ratio reported to vary from 20:1 to 4:1), with the highest incidence of onset in late adolescence to early adult life. [5]No age group is exempt, and onset in older age, as well as the occurrence of the condition in children as young as eight years old, has been documented in the literature.[6] The condition used to be more common in people with a background of medical knowledge. This bias is less obvious in a modern and well-informed society that has more access to media and the internet.

Pathophysiology

Adults with the disease may have associated neurosis, personality disorders, impulsiveness, or depression. The patients may assume a sick role which may allow avoidance of adult responsibilities. There may be associated self-hate and guilt. Children may have associated anxiety or immature coping styles to various psychosocial stresses. The fictitious illness may symbolize anger or conflict with authorities, for example, a school phobia.

History and Physical

The typical presentation includes cutaneous lesions which are bizarre and mimic many of the known inflammatory reactions in the skin[7]. The fabricated history that follows is usually “hollow," and there is no complete description of the genesis of individual skin lesions which appear suddenly and fully formed on accessible sites. More emphasis is given to describing the complications and failure to heal. The patients typically have a “la belle indifference” towards their predicament, showing a lack of concern, but their relatives may be angry and frustrated.[8][9][10][11]

The lesions may be circular blisters or erosions, burns, cryodamage, excoriations, urticarial lesions, hemorrhages, indurations, or necrosis. These may be consequences of an application of foreign bodies or chemicals.[12] Traces or evidence of these is noticeable on close examination of crude dermatitis. Any part of the body can be affected, but the most common site in all age groups is the face, followed by dorsum of hands and forearm of the non-dominant limb. The patients also may present with nonhealing postsurgical wounds.

Classic location of dermatitis artefacta includes the following:

- Face, most common
- Lower extremity, second most common
- Hands and forearm, third most common
- Trunk
- Upper arm and shoulder
- Scalp
- Neck

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

Most patients have more than one skin lesion. On the physical exam, the healthcare worker must differentiate the disorder from trichotillomania, excoriation disorder dermatitis neglecta. Sometimes the skin lesions may be severe and mimic a T cell lymphoma, hemophilia, and porphyria cutanea tarda.

Evaluation

The clinical presentation, including distribution and physical characteristics, are almost diagnostic. The typical presentation in the context of a psychiatric constellation differs from that of neurotic excoriations, delusional disorders, malingering, and Munchausen syndrome (hospital hoppers who fake illness without motivation by external incentives). The differential diagnoses to be considered for crusted, blistering lesions include ecthyma and herpes simplex. Others may simulate porphyria cutanea tarda, epidermolysis bullosa acquisita, amyloidosis, vasculitis, pyoderma gangrenosum, cutaneous lymphoma, drug eruptions, or loxoscelism.

Treatment / Management

The skin lesions may need treatment with topical antibiotics, but in some cases, one may need oral antibiotics if there is evidence of a severe infection.

The underlying mental health disorder must be addressed and treated. The usual drugs include antipsychotics, antidepressants, and sedatives. NSAIDs may be prescribed, but opiate and other prescription analgesics should be avoided for fear of inducing addiction and physical dependence.[13][14][15][16]

If the individual has evidence of depression, then reports indicate that SSRIs should be the drugs of choice. Tricyclics also are helpful for patients with itching and insomnia. Tricyclics also help relieve pain and depression.

Prolonged use of antipsychotics should be avoided because they also have potent side effects. However, in patients with delusional and psychotic features, antipsychotics can be beneficial.

The patient's denial of psychological distress and negative feelings aroused in healthcare personnel make management

difficult. The doctor should create an accepting, empathic, and non-judgemental attitude and avoid confrontation. Close supervision and good symptomatic care of skin lesions permit the development of a therapeutic relationship in which psychological issues may gradually be introduced, which may occasionally permit a psychiatric referral. When the patient refuses a psychiatric referral, the use of psychotropic drugs by dermatologists is helpful and appropriate[17]. The upper dose range of SSRIs or low-dose atypical antipsychotic agents may be effective. Except in mild transient cases triggered by an immediate stress, the prognosis for cure is poor. The condition tends to wax and wane with the circumstances of the patient's life. Lesions can be kept to a minimum, and the patient can be protected from unnecessary and intrusive studies with ongoing supervision and support and regular outpatient reviews.

Dermatitis artefacta is a long-term disorder, and patients need regular follow up with a dermatologist and a psychiatrist because relapses are common. Many patients are noncompliant with treatment and often fail to follow up.

Differential Diagnosis

- Alopecia Areata
- Anagen effluvium
- Bedbug bites
- Delusions of parasitosis
- Friction blisters
- Impetigo
- Insect bites
- Irritant contact dermatitis
- Onycholysis
- Telogen effluvium

Prognosis

For patients with mild cases of dermatitis artefacta associated with common stressors like pressure, anxiety or depression, the prognosis is good. However chronic cases of dermatitis artefacta that are associated with medical problems and chronic skin damage usually have a guarded outcome. These people usually cannot be cured, and relapses are very common. When the condition is left untreated, it can lead to severe self-mutilation and poor aesthetics with disfiguring scars. Tragically, suicide is also a real potential outcome in some of these patients.

Enhancing Healthcare Team Outcomes

The diagnosis and management of dermatitis artefacta is complex and best done with an interprofessional team that includes the primary care provider, nurse practitioner, psychiatrist and dermatologist. While the skin lesions may need treatment, the underlying mental health disorder must be addressed and treated. The usual drugs include antipsychotics, antidepressants, and sedatives. NSAIDs may be prescribed, but opiate and other prescription analgesics should be avoided for fear of inducing addiction and physical dependence.

The patient's denial of psychological distress and negative feelings aroused in healthcare personnel make management difficult. The doctor should create an accepting, empathic, and non-judgemental attitude and avoid confrontation. Close supervision and good symptomatic care of skin lesions permit the development of a therapeutic relationship in which psychological issues may gradually be introduced, which may occasionally permit a psychiatric referral.

Dermatitis artefacta is a long-term disorder, and patients need regular follow up with a dermatologist and a psychiatrist because relapses are common. Many patients are noncompliant with treatment and often fail to follow up. The prognosis for most patients is poor- leading to self injury, scarring and poor cosmesis.[18][19]

Continuing Education / Review Questions

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