Review Article

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Dermatitis Artefacta: A Cry for Help

Vandana S Thangavel

Authors Affiliation
[1]Assistant Professor, HOD Mental Health Department, MKSSS, Sitabai Nargundkar College of Nursing Hingna, Nagpur 441110 Maharashtra, India.

Corrosponding Affiliation
Vandana S. Thangavel, Assistant Professor, HOD Mental Health Department, MKSSS, Sitabai Nargundkar College of Nursing Hingna, Nagpur 441110 Maharashtra, India.
Email: vandanaswaran@gmail.com

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Abstract

Dermatitis artefact is a rare psychocutaneous disorder. This disorder always mismatched with a diagnosis of a dermatological origin. But actually the patient with Dermatitis Artefacta needs psychiatric consultation in priority and rest all treatment is for symptomatic relief. A patient MS. Sarita came in mental hospital with multiple painful erythematous plaques on forehead with oozing of blood. (Name of Hospital and Patient has Changed to Maintain Confidentiality). The disorder is having poor prognosis. Its a long term disease as well as most challenging case for the psychiatrist.

Keywords: Dermatitis Artefacta; Rare; Poor Prognosis; Psychiatric origin.

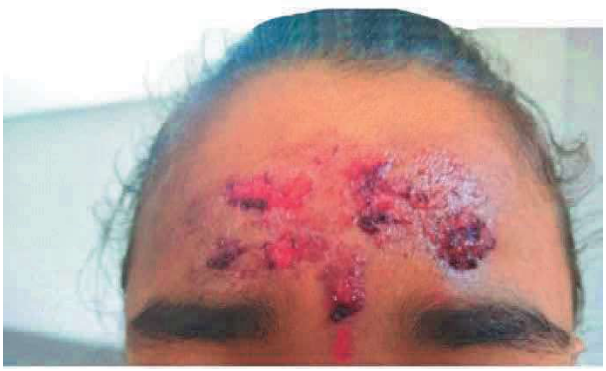
Case Report

Ms. Sarita 15 yr. old girl second of the 4 sibling presented with multiple erythematous plaques on forehead with oozing of blood. there was no history of any injury, burn, insect bite, or drug or food allergy. In the beginning of interview she refused any self inflicting nature of her injury such as scratching or rubbing with any object while interview her father was with her. The lesions were bizarre, with a tapering end at various stages of healing, and were not compatible with any known dermatological disorder. None of laboratory investigations reveled any kind of dermatological origin of lesions.

In later stage of interview she accepted that she was doing this since 6-7 yrs.

Signs and symptoms she was showing repetitive peeling of skin until oozing of blood starts.

Assessment: CAT (Child Apperception Test) Conducted for her which revels some of the reason which can be taken into consideration such as family dispute, disturbed parent child relationship. Which was the major cause in our case. However psychiatrist dealing with the case reported this case as challenging case.



Discussion

Introduction: Dermatitis artefacta is defined as the deliberate and conscious production of self-inflicted skin lesions to satisfy an unconscious psychological or emotional need. Patients with this condition require both dermatologic assessment and psychosocial support.[1]

Definition: Dermatitis artefacta DA is a type of factitious disorder produced by deliberate action of the patient to satisfy some deep-seated interpsychiatric need. Denial regarding the self-inflicted nature of injury/injuries is a common finding.[1]

Incidence:According to the literatures, this practice is more common in females, with onset during or after adolescence. Several creative methods and means are stated to be used, starting from burning with cigarettes to the use of caustic chemicals to inflict injury.[2]

Signs and Symptoms: The physician often notices that the patient enters the examination room with a stack of investigative reports and a bag of medications.

- Constant rubbing or picking of the lesions with a Mona Lisa smile (it means blurry ambiguous and upto the imagination) is not uncommon.
- Amnesia about the act.
- Other signature signs are bizarre-shaped lesions with various stages of healing; involvement of approachable body parts, most commonly the face and the dorsum of the hand.
- Normal intervening skin,
- Nonspecific histology,
- Normal blood test,
- And most importantly complete disappearance of the lesions under occlusion therapy.
- Basically, it is a disease of exclusion as numerous dermatological diseases.[2]

Type of Lesions: Shape of the lesions indicates the mode of infliction to a great extent.

- Tendency of linear configuration points toward chemical burn,
- Whereas circular ulcer(s) or blister(s) may be associated with cigarette burn.[2]

A prudent physician may even predict the potential sites for the reappearance of lesions in future visits.

Etiological Factors: Exact cause is unknown however Several factors such as.

- Delayed developmental milestones.
- Marital dispute.
- Loss of close relatives in the recent past.
- Self-guilt.
- Disturbed parent-child relationship.
- Bipolar personality disorders.
- Sexual and substance abuse.

are implicated as the precipitating factors.

The ultimate objective of the client having dermatitis is to assume a sick role to fulfill unconscious psychological need for dependency and to form stable body image and boundaries. In spite of the underlying psychiatric disturbances, the patient appears to be cooperative, unconcerned about his/her painful and puzzling lesions, or somewhat bewildered.

On the contrary, anxiety and frustration of the accompanying family members and inquisitiveness about the evolution of the lesions is noteworthy.[2]

Differential diagnosis: Important dermatological differentials are necrotizing vasculitis, pyoderma gangrenosum, and cutaneous T-cell lymphoma.

Munchausen syndrome should be considered as an important psychiatric differential, characterized by flamboyant males who feign multiple symptoms and shifting complains not limited to only the skin, just to draw attention.[2]

Management: Managing dermatitis artefacta is a challenging condition whose management require psychiatric as well as dermatological care equally.

Psychiatric Management: Antidepressants in the form of selective serotonin reuptake inhibitor and behavioral therapy are the mainstay of treatment.[2] A tricyclic antidepressant (TCA) with antihistamine, antipruritic, and antidepressant properties (eg, doxepin) is recommended for depression with or without agitation and with pruritus as the primary symptom. A TCA with analgesic properties (eg, amitriptyline) is appropriate for depression with pain sensations (eg, burning, chafing, or stinging) as the primary symptom.[3]

Dermatological care with bland emollient, topical antibiotics, and occlusive dressing should not be underestimated as the patients tend to be emotionally attached to their skin.

Other Nonpharmcological: An effective therapeutic relationship in dermatitis artefacta patients requires a nonjudgmental, empathetic, and supportive environment. Every effort should be made to avoid discussing the etiology of the condition or confronting the patient regarding the behavior. Developing a good rapport with the patient and encouraging the patient to return for follow-up appointments are important.[3]

Long Term Monitoring: Frequent follow-up visits with a dermatologist, a psychiatrist, or both are recommended for dermatitis artefacta patients. It should be kept in mind that such patients are often lost to follow-up.

In cases of Münchausen syndrome by proxy, removal of the child to a safe environment is mandatory.

A psychiatric evaluation is warranted in dermatitis artefacta patients if severe self-mutilation is noted or if there is any evidence of psychiatric illness, psychosis, suicide risk, or need for hospitalization.[3]

Complementary adjuvant therapies in dermatitis artefacta patients may include acupuncture, cognitive-behavioral therapy (eg, aversion therapy, systemic desensitization, or operant conditioning), biofeedback and relaxation therapy (eg, for anxiety-related dermatitis artefacta), and hypnosis.[3]

- Hospitalization may be required for some patients, depending on the severity of the skin lesions and the risk of suicide.
- No surgical management is required for this case.

Conclusion: DA is often a challenge for the clinicians because of its rarity, vague history, bizarre and polymorphic morphology, lack of decisive diagnostic tests, and poor therapeutic outcomes.[2] Still a gentle, nonjudgmental, and empathetic approach often works. A sense of hesitancy and difficulty in making eye contact are useful clues of such strange behavior which can be used for early diagnosis.

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