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Case report
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DERMATITIS ARTEFACTA - A LONG WAY FROM THE FIRST CLINICAL SYMPTOMS TO DIAGNOSIS

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SUMMARY

Dermatitis artefacta is a disease that occurs as a result of a self-inflicted injury to the skin. The problem quite often is undiagnosed for a long time until the clinical look of bizarre skin lesions combined with non-specific histology and normal blood tests lead to the final identification. This report presents the case of a 62-year-old man who was diagnosed after 10 years of duration of disease. We discuss the reasons for such behavior and the possibilities of dermatological and general interventions.

Key words: *dermatitis artefacta - skin ulceretions – diagnosis - treatment*

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INTRODUCTION

In many situations dermatologists encounter patients who produce skin symptoms or lesions. In such cases patients deliberately create the impression of having the disease in order to achieve some benefit. Dermatitis artefacta refers to the skin lesions produced by the patient, under the veil of secrecy, to satisfy an unconscious need to be taken care of (Millard et al. 2004). These patients damage their skin in the same manner as in course of the simulation but they do not admit the manipulation. They also do not malinger as they have no obvious gain from the disorder. Indeed, it is extremely difficult to comprehend why individuals intentionally inflict damage on themselves. The skin is the most common site for self-damaging behaviours because it is easily accessible and often the lesions are presented in an ostentatious manner. The major underlying theme is an attempt to alter or escape from an unsatisfactory situation by calling attention to oneself as a patient, victim or bearer of a mysterious problem. The patients have a severe psychiatric problem but are otherwise cooperative, allowing multiple diagnostic procedures or therapeutic measures. Characteristically, the patient with dermatitis artefacta appears remarkably unconcerned, and somewhat bewildered , in face of lesions that are morphologically bizarre, often geometric in outline, destructive, and reportedly of sudden, mysterious yet fully formed appearance (Koblenzer 2010).

CASE REPORT

A sixty two-year-old Caucasian male was admitted to the Department of Dermatology due to ulcerations located on the face (Figure 1). The first symptoms at the same location appeared 10 years before the current admission and since then he started diagnostic procedures. He was hospitalized because of this many times in different clinics. The patient had 8 biopsies from the skin lesions due to histopatological and immunohistochemical examinations, as well as multiple microbiological tests on the basis of ulcerations swabs. He also had a head CT as well as abdominal ultrasonography. Laboratory examination revealed no alternations in renal and hepatic functions, in the electrolytes as well as in the haemogram. In spite of all these diagnostic procedures the final diagnosis had not been established.

During this time he was treated with topical (erythromycin, clindamycin, fucidic acid, mupirocin) and oral antibiotics (ciprofloxacin, amoxicillin with clavulonic acid, clindamycin, tetracycline, rifampicin) as well as oral retinoids. He also used oxygen hyperbaric therapy and accupressure. Moreover he was under bacteriophage and autovaccination treatments as well as vaccination with human gammaglobulines. None of these therapies gave a positive clinical result.

At the day of admission to our department the patient presented widespread ulceration covered with a serous exudate and atrophic scars located on the cheeks (Figure 1). He reported the skin lesions being extremely painful nodules inducing sleep disorders and related to ingestion of painkillers in order to be able to sleep (usually 3 pills of ibuprofen). The patient denied any manipulations of the skin like scratching or pressing out.

Surprisingly, he had a detailed documentation of history of his disease prepared by himself. Apart from medical documents he had his own "notes" in which he accused doctors of ignorance and lack of competence. Moreover he always carried a pocket mirror in which he checked himself very frequently during the day as was noticed by nurses at our department.

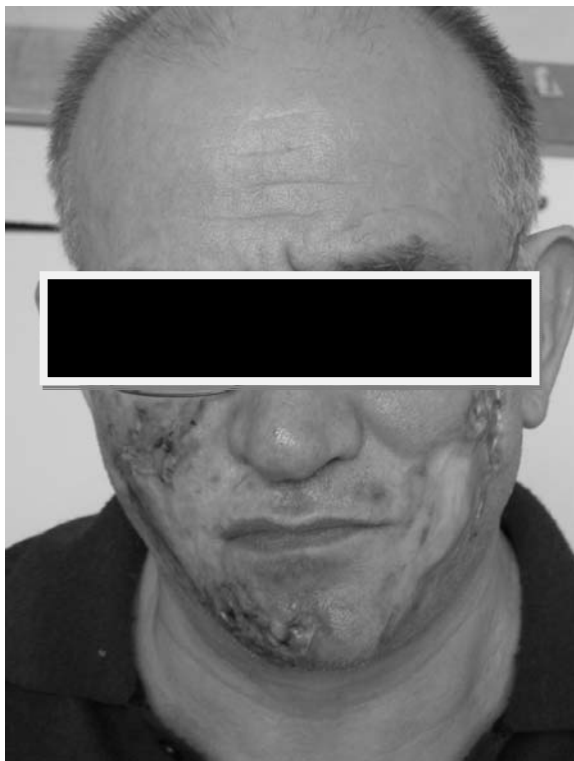

Figure 1. The patient at the day of admission to hospital

The patient's mood was low because of personal and work problems as well as because he had no hope for recovery. No abnormalities were observed at the physical examination as well as in laboratory biochemical and immunopathological tests. Histopatological examination did not define any dermatological disorder.

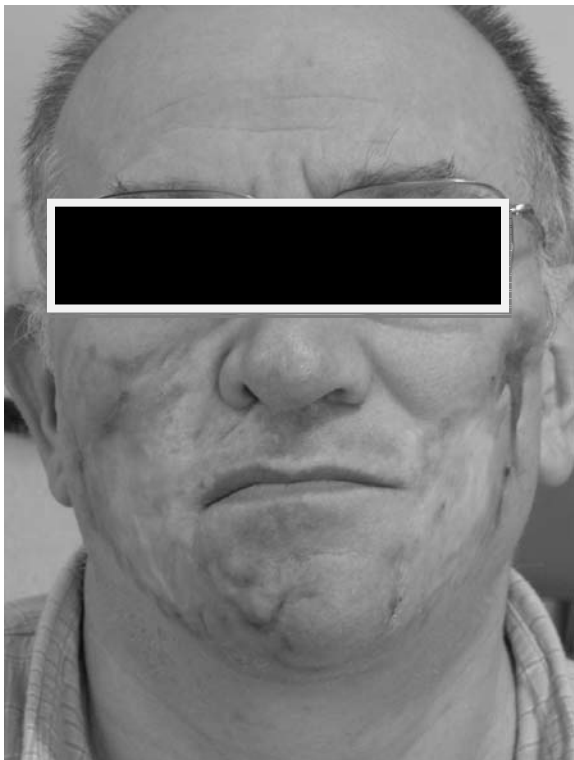

Figure 2. 12 days after admission

After exclusion of the majority of dermatological diseases the suspicion of dermatitis artefacta was considered. As a result of the psychoeducation performed the patient finally confessed that he himself was provoking the skin lesions. He insisted that the whole problem began with extremely painful nodules and scratching them with nails or a needle gave him relief and an opportunity to fall asleep. He mentioned that the nodules contained long, thick white hair. The psychiatric consultation confirmed dermatitis artefacta.

The patient was treated with venflaxine (150mg/d) and cream with silver nitrate under occlusion with a very good clinical result over 3 weeks (Figure 2 and 3). He was wearing dressings on the face for 24 hours that were changed by nurses twice a day. We did not observe any new skin lesions during his stay at our Department. He did not require any painkillers either.

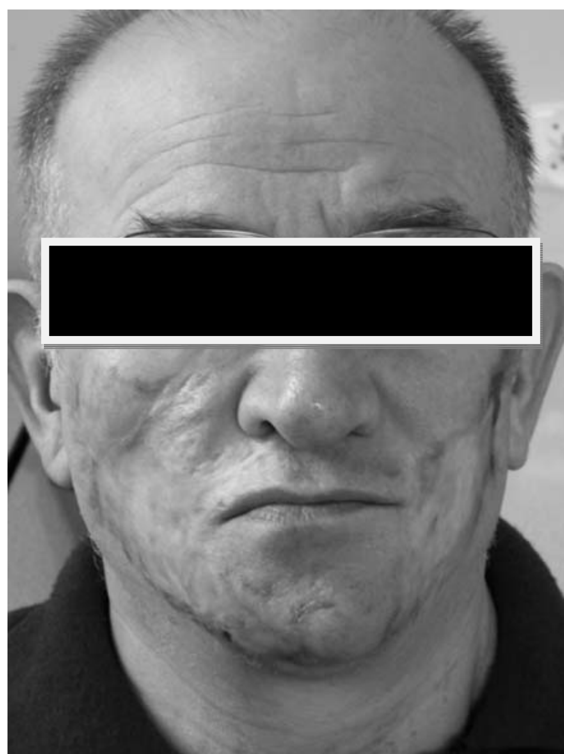

Figure 3. The patient at the day of discharge from hospital

He was discharged from our Department with the recommendation of frequent follow-up visits (twice a week). Unfortunately he has not shown up.

DISCUSSION

The skin occupies a powerful position as an organ of communication and plays an important role in socialization throughout life. Dermatitis artefacta is a disease that occurs as a result of a self-inflicted injury to the skin (Gupta 2005). It may masquerade as numerous dermatological disorders and should be considered after exclusion of other skin diseases. As we demonstrated the patient has been treated for 10 years with no

diagnosis established. He also avoided seeing the same doctor more than one time, which prolonged diagnostic procedures. The patient's anamnesia about his past and analysis of his personal notes, the results of the diagnostic tests as well as rapid healing during hospitalization led to a diagnosis of dermatitis artefacta. He had not talked with a psychiatrist before and he agreed to a consultation during his stay at our Department. Finally he described to the psychiatrist how he was making his ulcerations and confessed to relief after making them. It has been reported that neurotic excoriation is the commonest psychocutaneous disorder (Arnold 2001). Mood and anxiety disorders as well as depression, impulsive manner and somatization disorders are common in patients with dermatitis artefacta (Ehsani 2009). Comorbidity of depression and dermatologic disorders is around 30% (Filaković et al. 2009). Summing up all biopsies, microbiological specimens, blood tests, consultant opinions, hospital admissions and drugs the cost of the final diagnosis in our patient was very high. Frequent short visits, ostensibly for supervision of topical therapy, allow a therapeutic alliance to evolve in a nonjudgemental environment. The role of medications is highly debatable and several studies have reported contradictory results (Kalivas 1997). Some psychiatrists suggest that there is an exaggerated grooming response where the patients have learned to acutely damage their skin and liberate endorphins centrally to diminish their anxiety and tension (Cotterill 1992). Besides the psychiatrist and dermatologist, the therapeutic team should include other experts whose collaboration could help in developing treatment of comorbid disorders (Filaković et al. 2009).

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