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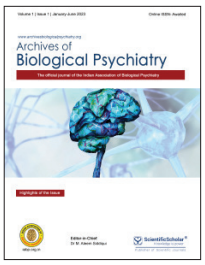

Case Report *Psychiatry*

Unraveling the enigma: A case report on factitious dermatitis – exploring the complexities of psycho-cutaneous disorders

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Received: 23 January 2024
Accepted: 15 February 2025
Epub Ahead of Print: 13 March 2025
Published:

DOI
10.25259/ABP_4_2024

Quick Response Code:

ABSTRACT

Dermatitis artefacta (DA) is a condition in which skin lesions are solely produced or inflicted by the patient's own actions. This usually occurs as a result or manifestation of a psychological problem. It could be a form of emotional release in situations of distress or part of an attention-seeking behavior. It is particularly common in women and in those with an underlying psychiatric diagnosis or external stress. The diagnostic process relies on excluding other possibilities, making confirmation challenging. Patients frequently hesitate to acknowledge their involvement in the development of their lesions. Treatment can be challenging, and management should adopt a multidisciplinary team approach composed of dermatologists and mental health professionals. We present a literature review of DA, highlighted by a case report of a patient with ulcerations all over the face, which, after thorough investigation, represented DA.

Keywords: Factitial dermatitis, Multidisciplinary team, Self-induced, Skin ulceration, Stress

INTRODUCTION

Dermatitis artefacta (DA), also known as factitial dermatitis, is a condition whereby self-induced skin damage is the means used to satisfy a conscious or unconscious desire to assume the sick role.[1] These patients may fabricate lesions on the skin, hair, nails, or mucous membranes as a means to satisfy psychological desires, seek attention, or avoid accountability. By intentionally mimicking symptoms and manifesting signs of illness, patients strive to adopt the role of a patient. While ulcerations are frequently observed, other morphologies may emerge, dictated by the individual's level of motivation. Another critical function of DA is that the sufferers disguise their position in generating the symptoms of their condition; this concealment is what differentiates DA from different self-inflicted dermatoses, such as self-mutilations by psychotic patients, neurotic excoriation and trichotillomania.[2] To accurately diagnose this condition, it is essential to assess the nature of the injuries, the circumstances surrounding their appearance, and the patient's personality. Given that factitious dermatitis represents a somatic manifestation of a severe mental disorder, often unknown to the patient, a comprehensive interdisciplinary approach involving psychiatry is imperative for effective treatment.

CASE REPORT

We report a case of factitious dermatitis in a 45-year-old farmer from a rural background with a lower socioeconomic status. The patient presented with complaints of excessive itching and an irresistible desire to scratch, accompanied by multiple skin erosions and ulcers in various stages of healing on the face, which had been ongoing for the past 3.5 years.

The condition began with simple itching on the face while the patient was working in his paddy field. A few days later, he noticed the eruption of multiple tiny papules on his forehead and at the bilateral angles of the mouth. He continued scratching the lesions, which caused the papules to burst, providing temporary relief from the itching. Within the next month, the patient's scratching caused multiple abrasions and bleeding spots on his face. He sought treatment from a non-registered practitioner in his village for the next 3 months, but there was no significant improvement.

Subsequently, the patient switched to homeopathic treatment at a local facility for the next 3 months. However, there was no improvement, and his condition worsened. With continued scratching, the patient developed ulcerations on his forehead, bilateral angles of the mouth, and chin. Due to the lack of improvement, he sought care in the dermatology department of a private medical college in Lucknow, where he was admitted for 15 days. A series of tests, including direct immunofluorescence studies, Gram stain, bacterial cultures, and fungal cultures, were all negative. Anti-nuclear antibody tests and viral markers were also normal. He was discharged with oral and topical medications, but his itching persisted.

Due to financial constraints, the patient discontinued treatment for the next 8 months. During this time, the continuous itching and the sensation of new papules forming on his ulcerated wounds resulted in the development of multiple lesions on his face, ranging from superficial abrasions and erosions to deep ulcers with bleeding spots.

Finally, the patient presented to the dermatology department of Hind Institute of Medical Sciences, where, after a thorough workup and punch biopsy of lesions, the results showed neutrophils, histiocytes, lymphocytes, and eosinophils around the ulcer bed with no signs of malignancy [Figure 1]. The patient was referred to the psychiatry department for further evaluation. The patient was admitted to Psychiatry Department for observation. During his stay, no new papule eruptions were noted, but fresh wounds continued to appear.

A detailed history revealed that the patient's interpersonal relationship with his wife was unsatisfactory, with frequent conflicts. As the sole breadwinner for a family of six, he had been under significant stress for the past four years due to the family's poor financial condition. Interestingly, the patient reported that his relationship with his wife and family had improved since his illness, and he was receiving more affection and care than ever before.

Based on the comprehensive evaluation, the final diagnosis of L98.1 (Factitious Dermatitis) and F32.10 (Moderate Depressive Episode without Somatic Syndrome) was made.[3]

Mental status examination

Middle-aged looking male, ectomorphic built, dressed appropriately as per his socioeconomic status, few times itching over the face during the interview, cannot sit still, eye contact was made and sustained, bit irritable, rapport partially established. Psychomotor activity was slightly decreased, productivity was normal, affect appeared anxious and depressed and congruent to mood, thought content had worries of future and anxious ruminations, attention was arousable and sustained, intact judgment, grade-4 insight. The patient was provisionally diagnosed with Factitious Dermatitis with Moderate Depressive Episodes without the somatic syndrome.

Management

For management, the patient was admitted to the Department of Psychiatry. A combined approach involving both the Psychiatry and Dermatology departments was used to address the patient's needs.

For skin infections, oral and topical antibiotics were initiated. To alleviate itching and inflammation, an H1 antihistamine was prescribed. For pain and further inflammation, non-steroidal anti-inflammatory drugs were started.

The patient was also started on Duloxetine 20 mg twice daily (BD), which was gradually titrated to 30 mg BD within 1 week. In addition, amitriptyline 10 mg once daily (OD) and clonazepam 0.25 mg BD were prescribed.

Dialectical behavioral therapy, a structured behavioral therapeutic program, was introduced.

This comprehensive approach led to significant improvement in the patient's condition. The intense desire to scratch diminished within 1-week, wound healing began within 10 days, and complete wound healing, along with cessation of itching, was achieved within 8 weeks [Figures 2 and 3].

Although the patient was discharged after 2 weeks of hospitalization, follow-up visits were scheduled weekly. During these visits, the patient showed complete resolution of symptoms [Table 1].

Table 1: Hamilton rating scales applied.

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Hamilton anxiety rating scale	23	20	18	21	16	16
Hamilton depression rating scale	21	20	17	17	15	13

DISCUSSION

DA refers to conditions where skin lesions appear mysteriously, with the patient denying any involvement in causing them. These lesions often reflect underlying psychological anxiety, which must be thoroughly explored. Removal of linear nails or sharp objects is the second most common manifestation of DA, following ulcers. The disease is diagnosed using the classification system outlined by Gupta and Gupta.,[4] in their work on "diseases associated with spontaneous eruptions," which is essentially self-explanatory. The average age of presentation is typically above 20 years, with a higher incidence in females and a greater prevalence in lower socioeconomic groups.

The patient history in these cases is often vague or "hollow," and it is crucial to rule out conditions such as psychosis or malingering. According to Lavery *et al*.,[1] the diagnosis of DA requires a high level of suspicion, a careful evaluation of dermatological symptoms, and an in-depth psychological assessment. Consequently, management involves an eclectic approach combining an empathic patient-physician relationship, a supportive environment, psychotherapeutic interventions, and pharmacological treatment, all of which require effective communication.

The lesions in DA can vary as different tools and methods are used to produce them.[5] Based on the dermatologist's opinion in this case, the patient's lesions resembled hesitation and deliberate self-harm, a behavior also observed in psychiatric patients with borderline personality disorder (BPD).

BPD is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and emotional regulation, with marked impulsivity being a central feature. Deliberate self-harm in DA, however, is driven more by underlying negative emotional states. A cognitive-behavioral approach, combined with a passive yet empathetic psychiatrist-patient relationship, is often more effective in managing these patients.[6] Furthermore, pharmacological treatment differs between the two conditions. While stress and anxiety in DA generally respond well to selective serotonin reuptake inhibitors, great caution must be exercised when treating patients with BPD to avoid triggering mood disturbances or causing switching.

Figure 1: Wounds in different stages of healing at week 1. (Multiple well defined erosive areas of size varying 0.5 × 0.5 cm to 4 × 3 cm,presented over forehead,above nasal ridge and chin).

Figure 2: Wounds in different stages of healing at week 4. (Multiple erosive areas with healed granulation tissues surrounding hyper-pigmentation of size varying 0.5 × 0.5 cm to 4 × 3 cm present over forehead,above nasal ridge and chin).

In our case, we carefully excluded other psychiatric disorders and serious conditions through detailed clinical and psychometric evaluations, including the use of the International Personality Disorder Examination Screening Questionnaire. This thorough approach was essential for both accurate diagnosis and effective management.

Our case underscores the importance of a detailed assessment of deliberate self-harm in clinical practice, as well as the necessity of consulting the dermatology department. This collaboration allows the psychiatrist to remain open to a wider range of possibilities and ensures

Figure 3: Wounds in different stages of healing at week 8. (Decrease in erythema and increased granulation tissues in all erosive lesions with re-epithelialization in erosive lesions of forehead and chin).

they look beyond the surface when diagnosing. Early recognition and appropriate management of DA can lead to a favorable outcome.

CONCLUSION

Accurate diagnosis and collaborative approach of Psychiatry and Dermatology is of foremost importance. Atypical presentation leads us to believe that DA may remain underdiagnosed. Early recognition is useful for appropriate management and minimizes risk and suffering, including financial loss.

Acknowledgment: I wish to express my sincere gratitude to Dr. Jaymin and Dr. Divya, JRs in the 1st year, for their invaluable assistance. Their collaboration and support have significantly contributed to the success of this journal. I am truly appreciative of their dedication and contributions to this endeavor.

Ethical approval: The Institutional Review Board approval is not required.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent.

Financial support and sponsorship: Nil.

Conflicts of Interest: There are no conflicts of interest.

Use of artificial intelligence (AI)-assisted technology for manuscript preparation: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

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How to cite this article: Singh R, Pathak A, Singh M, Rana Y, Yadav V. Unraveling the enigma: A case report on factitious dermatitis – exploring the complexities of psycho-cutaneous disorders. Arch Biol Psychiatry. doi: 10.25259/ABP_4_2024