NEUROPSYCHOCUTANEOUS DISORDERS

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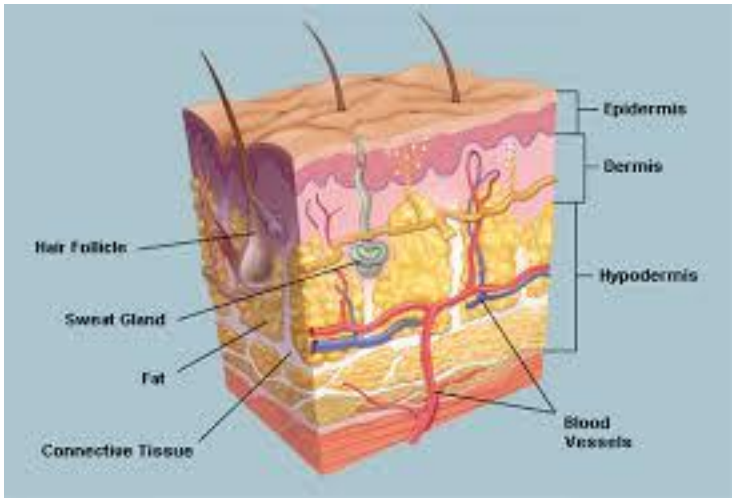
Disclosures

- No relevant financial relationships or conflicts of interest to disclose.

Psychodermatology

- Cutaneous disorders psychiatric in nature, with absence of organic dermatologic causes.



Delusions of Parasitosis

- Firm fixation that he/she has parasitic infection.
  - Close contact may share delusion.
- Female: Male 2:1, middle to older age.
- "**ziplock sign**" patient will often bring in epithelial debris in ziplock as proof.
- Associated with schizophrenia, depression, anxiety, drug/alcohol abuse, dementia and obsessive states.
- May experience sensations of biting, crawling or stinging.
- Practitioner needs to distinguish delusion from substance-induced formication.
- Skin Findings range from none to excoriations, lichenification, prurigo nodularis and/or frank ulcerations.

Delusions of Parasitosis: Management

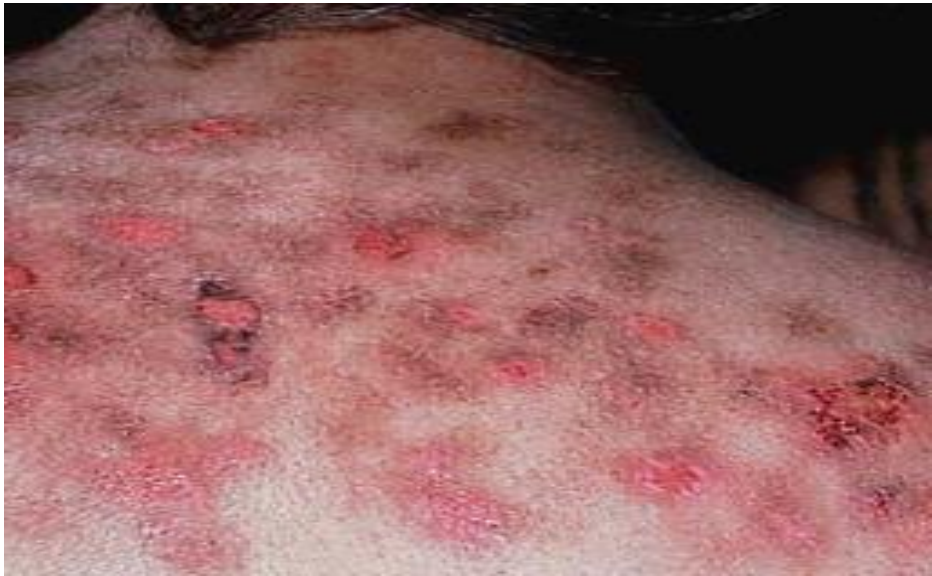
- Establish rapport with the patient and to address the chief complaint seriously, making sure to do a thorough dermatologic examination.
  - Diagnosis of exclusion, rule out infestation, underlying dermatologic condition.
  - Consider biopsy and laboratory workup to rule out organic etiology.
- Present antipsychotic medication in pragmatic manner.

Delusions of parasitosis: Management

- Psychiatry is preferable but is often rejected by the patient.
- Past: Pimozide 1-4mg treatment of choice.
  - SE extrapyramidal & prolonged QT interval
- Newer atypical antipsychotic agents like risperidone and olanzapine are now consider first-line agents.
- With appropriate pharmacologic intervention, some literature suggestion 50% of patients will remit.

Psychogenic (neurotic) excoriations

- Unconscious compulsive habit of picking at themselves, so persistent that excoriations develop.
  - Typical on contralateral side of hand dominance.
  - Could be ritualistic or random areas.
- Most common in middle-aged women.
- Different degrees of healing and scarring.
- Most commonly associated with depression, obsessive-compulsive disorder and anxiety.

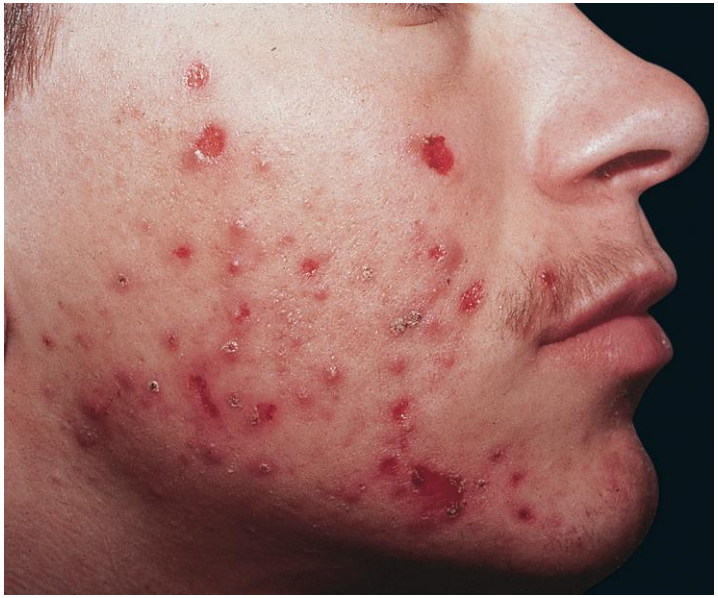


Neurotic Excoriations - Management

- Treatment is difficult, psychiatric and behavioral intervention can be very useful.
- IL corticosteroids, flurandrenolide tape for old lesions.
- On average lasts 5-8 years with exacerbations paralleling stressful events.
- Treatment of choice is doxepin.
  - if major depression is present use antidepressant dose 100mg/day. 50-75mg or 10-20mg per day for elderly also works.
  - If underlying OCD component, consider SSRIs.
- A case study of treatment-resistant excoriation disorder found that the addition of aripiprazole to venlafaxine resolved her disorder.
  - Turner GA, et al. Augmentation of Venlafaxine with Aripiprazole in a Case of Treatment-resistant Excoriation Disorder. *Innov Clin Neurosci*. 2014 Jan;11(1-2):29-31.

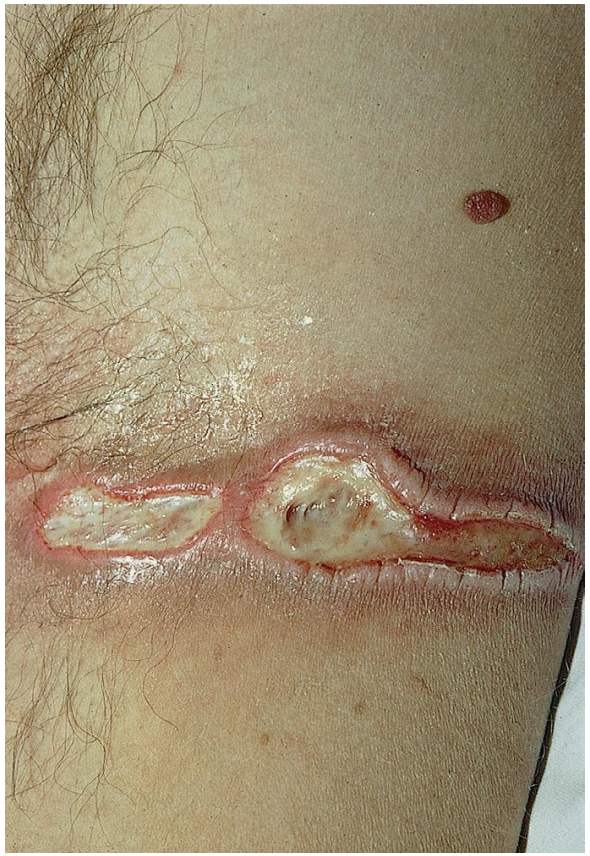
Acne Excoriee

- Frequently seen in young women.
- Subset of neurotic excoriations.
- Ritualistic picking of acne lesions.
- Tx: Doxepin and SSRIs.



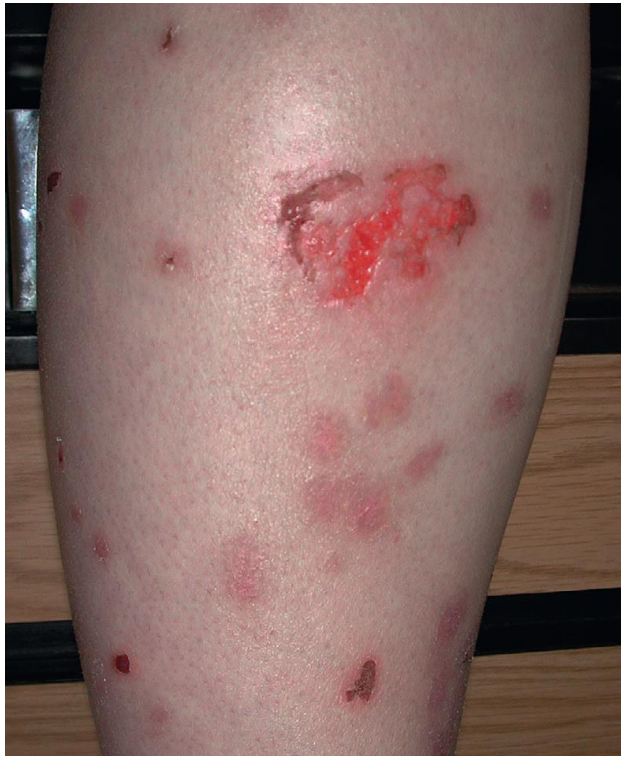
Factitious dermatitis (dermatitis artefacta)

- Self-inflicted cutaneous lesions often induced by foreign objects with intent to elicit sympathy, escape responsibility, or collect financial benefit.
- F:M 3:1, typically midlife.
- Most suffer from borderline personality disorder.
- Dermatologic findings that do not match history.
  - Typically located in areas that are easily reached by the hands.



Factitious dermatitis (dermatitis artefacta)

- Various forms and subsets.
- **Munchausen** syndrome: patients create lesions to match a particular known condition.
- **Munchausen by proxy**: patients induce lesions and abuse on a child to gain attention.



Factitious Dermatitis - Management

- Wound care.
- Exclude possible primary skin disorder.
- Recognize signs of anxiety disorder and signs of depression.
  - Psychiatry, psychotherapy, antidepressant, antianxiety or antipsychotic medications.

Gardner- Diamond syndrome

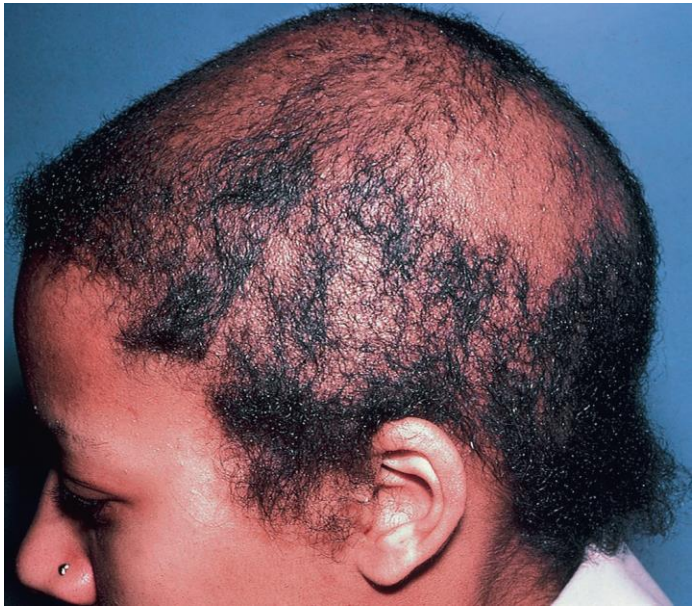
- Factitial disorder.
- Clinically presents with **painful swollen ecchymoses** at sites of trauma.
- Women with underlying psychiatric disorder.
- Treatment: difficult, psychiatry.

Trichotillomania (trichotillosis or neuromechanical alopecia)

- Neurosis characterized by abnormal urge to pull out hair.
- Commonly affecting the scalp, eyebrows, eyelashes, pubic hair and the beard.
  - On the vertex crown it is known as the **"friar tuck"** form.
- Nails may show **onychophagy**.
- Occasionally, **trichophagy**: patients may eat the hair causing intestinal obstruction with a trichobezoar.
  - **Rapunzel syndrome:** When the benzoar develops a tail of hair extending to and obstructing the small intestine.

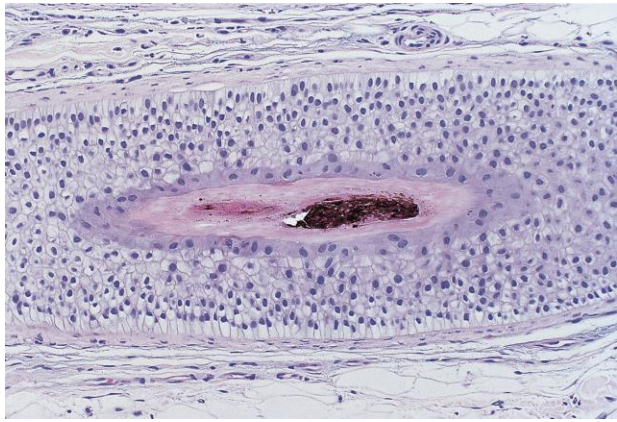
Trichotillomania

- Look for hairs of varying lengths.
- In some patients an area can be shaved to watch hair regrowth.
- **Epidemiology:**
  - 8 yo boys, 12 yo girls
  - F:M 5:1
  - Population prevalence 0.6%



Trichotillomania

- **Pathology:**
  - Presence of **pigmented hair casts** (also seen in traction alopecia).
  - Perifollicular lymphocytes, plasma cells and neutrophils are usually sparse or absent.
  - Perifollicular hemorrhage occasionally found in early lesions.
  - Perifollicular fibrosis - late change.
  - If the follicle is destroyed, a vertical fibrous tract often remains at the site.
- **DDx**: Alopecia areata, tinea capitis



Trichotillomania

- **Treatment:**
  - Cognitive-behavioral therapy.
    - Self-monitoring, teaching the patients to do something else whenever they are feeling the urge to pull their hair, relaxation techniques and positive reinforcement.
  - Pharmacotherapy with clomipramine and SSRIs.
    - Olanzapine or N-acetylcysteine also show promise.
    - Effects of inositol are currently being studied.

Leppink EW, et al. A double-blind, placebo-controlled study of inositol in trichotillomania. *Int Clin Psychopharmacol*. 2016 Nov 7. [Epub ahead of print]

Dermatothlasia

- Cutaneous compulsion to pinch and rub skin until bruising.

- Often a defense to pain at a different location.

Bromidrosiphobia

- Delusion of bromhidrosis.
  - Patient is convinced his/her sweat is creating a repugnant odor keeping people away, despite contrary evidence.
- Male: Female 3:1, average age 25.
- Atypical antipsychotics pimozide may be beneficial.
- Can be an early sign of schizophrenia.

Body dysmorphic disorder

- Excessive preoccupation with having an ugly body part.
- 10-14% of dermatology patients.
- Starts commonly in early childhood.
- Patient is preoccupied with slightest defects in appearance.
- Associated with compulsive, ritualistic behaviors.
- Frequently centered around nose, mouth, genitalia, breasts and hair.
- Commonly present for cosmetic surgery evaluation.
- Presence of varying degrees of insight (in contrast to psychosis, where, by definition, there is essentially no insight).
- Associated with depression, somatoform disorder and social isolation.

Body Dysmorphic Disorder - Management

Two categories:

- Obsessive compulsive – display OCD behaviors, come in for multiple visits.
  - Tx: SSRI (first line)
- Delusional – no insight on their condition.
  - Tx: Antipsychotocs
- Both categories are never satisfied with their surgeries.
- Treatment includes cognitive-behavioral therapy.
  - Harrison et al. Cognitive-behavioral therapy for body dysmorphic disorder: A systematic review and meta-analysis of randomized controlled trials. *Clin Psychol Rev*. 2016 Aug;48:43-51. doi: 10.1016/j.cpr.2016.05.007.
  - Hollander, et al. Relapse Prevention and the Need for Ongoing Pharmacological Treatment in Body Dysmorphic Disorder. *Am J Psychiatry*. 2016 Sep 1;173(9):857-9. doi: 10.1176/appi.ajp.2016.16050624.

Scalp dysesthesia

- A subset of “cutaneous dysesthesia syndromes”.
- Characterized by pain and burning sensations without objective findings.
- Primarily women middle-age to elderly.
- Associated with cervical spine degenerative disc disease.
- Hypothesized to be from chronic tension on the occipitofrontalis muscle and scalp aponeurosis.
- Treatment is gabapentin and low dose SSRIs.

Burning mouth syndrome (glossodynia, burning tongue)

- A subset of "cutaneous dysesthesia syndromes".
- Burning sensation of oral mucosa without objective skin findings.
- Frequently postmenopausal women.
- Diagnosis of exclusion, rule out other causes.
- Treatment include topical lidocaine, capsaicin, doxepin, and alpha-lipoic acid as well as oral medications (SSRIs, TCAs and gabapentin).
- Low level laser therapy has shown some promise with larger studies needed.
  - Al-Maweri, et al. Efficacy of Low Level Laser Therapy in the Treatment of Burning Mouth Syndrome: A Systematic Review. *Photodiagnosis Photodyn Ther*. 2016 Dec 2. pii: S1572-1000(16)30253-8. doi: 10.1016/j.pdpdt.2016.11.017.

Vulvodynia

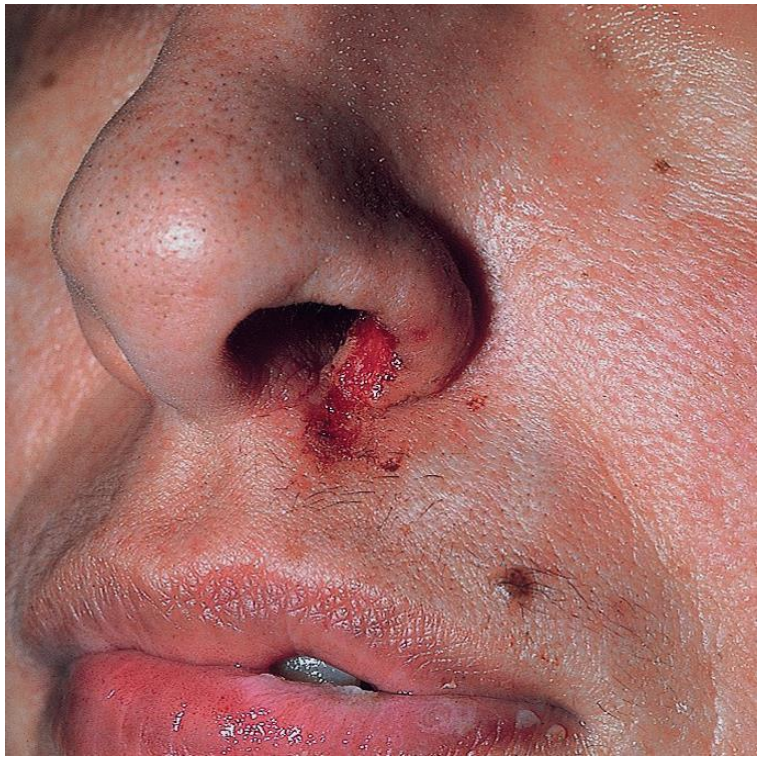
- Si/sx: Vulvar discomfort; burning pain; lasts 3 mo or longer.
  - Provoked by physical contact.
- Subtypes: localized and generalized.
- Epidemiology: Typically nulligravid woman in late 30s.
- Underlying causes must be ruled out (candida, endometriosis, neoplasia, contact dermatitis, hypoestrogenism, neurological etiologies).

Vulvodynia

- Tx: Pt education, psychological support, lubricants, elimination of irritants, antidepressants (SSRIs or TCAs), gabapentin, pregabalin.
- Topical analgesics are also a treatment option with a recent study supporting treatment with compounded creams (baclofen 5% & autacoid palmitoylethanolamide 1%).
  - Hesselink K. New topical treatment of vulvodynia based on the pathogenetic role of cross talk between nociceptors, immunocompetent cells, and epithelial cells. *J Pain Res*. 2016 Oct 3;9:757-762. eCollection 2016.

Trigeminal trophic lesions

- Interruption of peripheral or central sensory pathways of trigeminal nerve, resulting in a slowly enlarging anesthetic unilateral ulcer on nasal ala or adjacent cheek.
  - Nasal tip is spared.
- Biopsy to exclude tumor or infection.
- Etiology: ulcer is typically due to self-inflicted trauma to anesthetic skin.



Trigeminal trophic lesions

- Tx: Prevention by occlusion and psychotrophic medicine.
- Carbamazepine has also been investigated as a potential treatment option.
  - Upshaw WN, Bilyeu CW. Carbamazepine as a Treatment for Trigeminal Trophic Syndrome: A Case Report and Literature Review. *Psychosomatics*. 2015 Sep-Oct;56(5):580-2. doi: 10.1016/j.psym.2015.05.004. Review.
- A recent case report displayed successful treatment of TTS with a thermoplastic dressing.
  - Brewer JD, et al. The Treatment of Trigeminal Trophic Syndrome With a Thermoplastic Dressing. Dermatol Surg. 2016 Mar;42(3):438-40. doi: 10.1097/DSS.0000000000000636.

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