Acta Dermatovenerol APA

Acta Dermatovenerologica
Alpina, Pannonica et Adriatica

2014;23:13-15
doi: 10.2478/v10162-012-0047-7

Factitious disorders in adults: two cases of unusual skin ulcers

Giuliodori Katia[1*], Campanati Anna[1*] ✉, Rosa Laura[1], Marconi Barbara[1], Cellini Andreina[1], Brandozzi Giuliano[1], Giulia Ganzetti[1], Simoncini Annalisa[2], Offidani Annamaria[1]

Abstract

The factitious disorders (FDs) include a large group of dermatological conditions characterized by skin lesions that patients themselves self-inflict but deny their active participation. FDs usually represent a diagnostic challenge, and their therapeutic management is usually based on a multidisciplinary approach because most FRD patients also suffer from undiagnosed behavior and personality disorders. We report two cases of FD: one patient that was suffering from severe depression and induced third-degree chemical burns on his own lower limbs, and another patient affected by obsessive-compulsive disorder and anorexia nervosa that presented with deep self-inflicted ulcers on her face. Our multispecialist approach, based on close cooperation between dermatologists and psychiatrists, led to a significant improvement of clinical conditions in both cases. Dermatologists need to be aware that FDs are complex disorders and a multidisciplinary approach is usually recommended to control their clinical course.

Received: 30 October 2013 | **Returned for modification:** 19 November 2013 | **Accepted:** 4 December 2013

Introduction

Factitious disorders (FDs), also known as dermatitis artefacta or pathomimia, describe a set of faked of self-inflicted skin lesions created without a clear external incentive. Patients deny any role in the creation of the lesions due to possible dissociative episodes. These self-inflicted skin injuries are most commonly derived from prolonged and deliberate scratching with the bare hands, but sometimes patients induce skin lesions by means of sharp tools or other instruments (1).

FDs are classified as primary psychiatric disorders according to the DSM-IV-TR classification (2). Depression and anxiety are the two most frequent psychiatric disorders among FD patients (3). Patients usually show a previous history of emotional disturbances both during childhood and in adult life, which leads them to have feelings of isolation and insecurity. This situation drives patients to develop dissociative personality disorders as a primary defense mechanism, which can promote self-harm behavior as a way of dealing with traumatic events (3, 4).

FDs mainly affect women in late adolescence or early adult life. Their clinical manifestations are highly variable and do not conform to common dermatoses. The morphology of self-inflicted lesions depends on the tools used by patients and ranges from common manifestations such as erosions, ulcerations, fissures, and burns to less common features such as purpura, bruising, cheilitis, alopecia, edema, and nail dystrophy. Lesions are often located in skin areas that the patient can easily reach (e.g., the face, arms, legs, neck, and back) (4).

In this case series we briefly describe the diagnostic and therapeutic approach to two cases of FD that came to our attention.

Report of two cases

Case 1

A 76-year-old man was referred to our clinical observation for the presence of two ulcerative skin lesions, located on the legs in mirror-image locations. The lesions were painful and they had appeared 2 months earlier. Physical examination revealed two deep ulcerative lesions of 5 × 10 and 6 × 8 cm, respectively, with erythematous, sharp edges that reached to the underlying muscles (Fig. 1).

These lesions resulted from a self-harm practice initiated by the patient himself: family members reported that he self-injected diesel fuel, which caused deep, third-degree chemical burns. The patient was therefore admitted to our clinic for medical and surgical management. Cutaneous examination failed to reveal any dermatological diseases, and routine blood tests were within the normal range.

The psychiatric examination confirmed a diagnosis of anxiety and depression triggered by some critical episodes in his life: a partial gastrectomy due to gastric cancer and the recent death of his wife. Afterwards, long-term systemic treatment with psychotropic drugs was introduced by psychiatrists (citalopram 20 mg/day and alprazolam 2 mg/day). The ulcerative lesions were initially treated with curettage and topical medications such as hydrocolloid and hydrogel, and then with skin grafts (Fig. 2a, b).

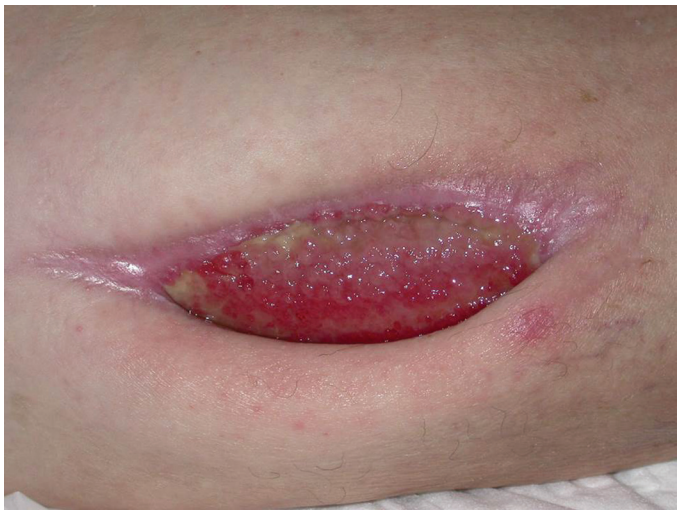
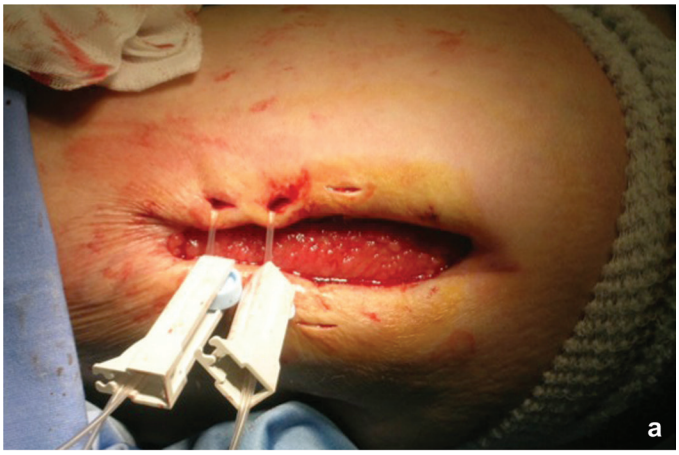


Figure 1 | Deep ulcer on the leg caused by self-injection of diesel fuel.

[1]Dermatological Clinic, Department of Clinical and Molecular Sciences, Marche Polytechnic University, Ancona, Italy. [2]Psychiatric Clinic, Department of Experimental and Clinical Medicine, Marche Polytechnic University, Ancona, Italy. *Authors equally contributed to the manuscript. ✉ **Corresponding author: a.campanati@univpm.it**



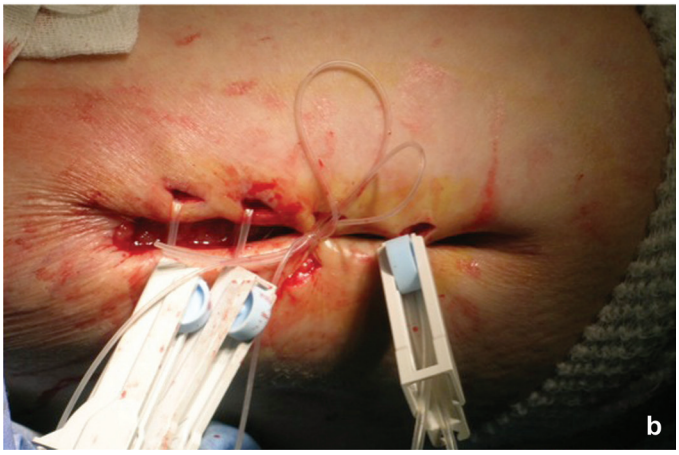


Figure 2a,b | Surgical treatment of the ulcer: application of skin grafts.

Case 2

A 40-year-old woman came to our attention for a single, round, ulcerative lesion 2 cm in diameter with mildly erythematous edges, located in the mandibular region (Fig. 3). The patient reported that she had been suffering from ulcerative lesions on the face for about 6 years, in a chronic and relapsing mode. She claimed to have already consulted many other dermatologists to solve this problem without any clinical improvement despite the treatments received.

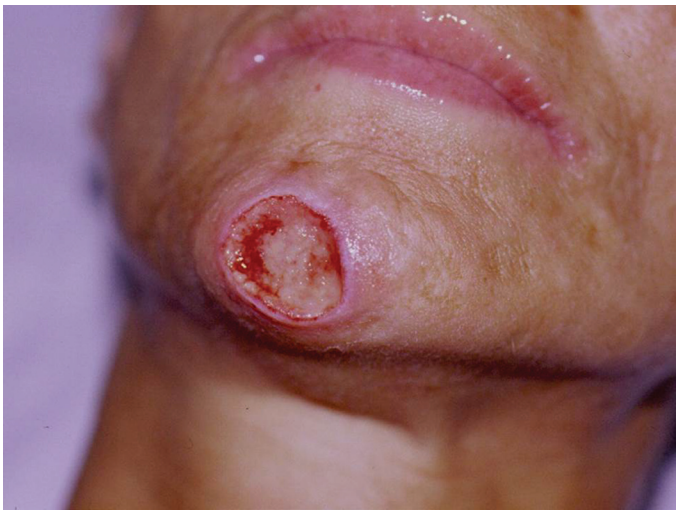


Figure 3 | Circular ulcerative lesion on the mandibular region self-inflicted by the patient.

However, the patient was unable to describe the prior treatments or produce previous prescriptions. During hospitalization she reported, despite considerable reluctance, congenital retinitis pigmentosa, congenital bilateral deafness, and a 12-year history of anorexia nervosa from the age of 26. Therefore she was sent for a psychiatric consultation that revealed a psychiatric profile characterized by previous anorexia nervosa with its typical features, such as body weight below the index of normality, secondary amenorrhea, obsessive-phobic beliefs about her body, self-induced vomiting, and dangerous feelings during the ideation of food. She also reported persistent, casual purgative practices and obsessive-compulsive personality traits, with a tendency toward perfectionism and self-blame, hypersensitivity to criticism, social withdrawal, and difficulty in managing self-directed aggression, expressed by explosive events.

The patient revealed that when stressful moments occurred, compulsive behavior generally emerged, aimed at reducing her anxiety: episodes of compulsive eating and vomiting and self-harm rituals were present. A skin biopsy was not performed due to the patient's reluctance. Thus an ex-adiuvantibus therapy with psychotropic drugs and psychotherapy support was started (sertraline 100 mg/day and delorazepam 15 droplets three times a day).

The dermatological approach relied on advanced occlusive dressings in order to minimize the possibility that the patient would manipulate the skin lesion. In about 6 months a slow healing of the wound started to be evident, accompanied by the patient's increasing awareness regarding its origin.

Discussion

According to Koo's classification (5), psychodermatological disorders can be grouped as:

1. Psychophysiological disorders, in which the patient's emotional processes determine the severity of dermatosis;
2. Psychiatric disorders that precede self-induced skin injuries;
3. Secondary psychiatric disorders that are secondary to a dermatological disease;
4. Cutaneous sensory disorders, in which the patient complains about itching or burning sensations without visible skin manifestations.

FDs are included in primary psychiatric disorders and several studies show that they are related to serious psychiatric illnesses such as schizophrenia, personality disorders, and dementia (3). Although the overall incidence of FD is not known, the importance of psychological involvement is emphasized by its strong association with borderline personality disorder and its higher prevalence in patients diagnosed with anorexia and bulimia (33%) (6). Diagnosis is often difficult because FD can be confused with other dermatoses and patients are reluctant to admit the real origin of their lesions. They typically show a "Mona Lisa–like" expression of artful innocence and they refuse psychiatric support but, at the same time, they tend to be demanding and manipulative (7).

The fear of missing organic diseases may induce a physician to request major and unnecessary analyses and therapies, which can also shift the focus away from the underlying emotional distress. In fact, the treatment cannot be separated from a psychiatric approach, which must support the dermatological treatments from the start of the patient's course of care.

The dermatological management of FD is difficult and variable, and it depends on the anatomical site and the patient's way of producing cutaneous manifestations (8, 9). Affected areas are usually easy to reach with various objects such as blades, knives, and other

sharp objects. Patients can also induce injuries simply with their hands or by self-injecting caustic or toxic substances into the skin. Sometimes it is also necessary to treat complications such as infections and scars (10–13).

Advanced medical devices can be used, and the gold standard is the occlusive dressing because it protects the patient from self-manipulation. In the first case report, the clinical diagnosis was easy to obtain thanks to information provided by patient's family. However, for the second patient the clinical diagnosis was obtained only after a careful multidisciplinary study of the case. We agree that it is unhelpful, and sometimes even damaging, to acknowledge patients' psychological disorders, as reported by many others in the literature (14). An admission of personal involvement is not necessary at all because it shakes patients' psychic defenses and may lead them to change doctors. In our cases, the early approach to the diseases was based on "how" and not on "why." In this way it was possible to first obtain the patients' confidence and cooperation and then their acceptance of the psychiatric care that is essential for a complete recovery.

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