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CASE REPORT

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Intentional or accidental? Case report of dermatological factitious disorder

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ABSTRACT

The self-induced dermatoses represent even about 2% of dermatology patient visits. Dermatological factitious disorder includes actions which lead to the damage of the body tissues without any suicidal intentions. It occurs rarely; thus, it can be misdiagnosed as a more common disease. It most often coexists with an emotionally unstable and immature personality. Accurate interviews and histopathology are of superior importance in diagnosis. Psychotherapy, antidepressants or antipsychotics are crucial in treatment.

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Keywords: factitious disorder, self-induced dermatoses, emotional instability, intentional dermatoses, psychodermatology

INTRODUCTION

Dermatological factitious disorder stays on the borderline of psychiatry and dermatology and involves the cooperation of these two specialities. Self-induced dermatoses represent 0.05 to 2% of dermatology admissions. Some authors found a higher prevalence of 8% in inpatient psychiatric units, with women being the most affected [1]. Dermatological factitious disorder concerns conscious and unconscious actions damaging body tissues, which is not associated with any suicidal intentions.

CASE REPORT

A 75-year-old man was admitted to the dermatology and venerology department due to a 4-year history of large shallow ulceration of a bizarre shape on the neck and occipital region (Fig. 1A, B).

In his internal medical history, he reported gastric ulcer, pneumonia, paresis of the right upper limb and back pain in the Th/L region. The two small, itchy skin lesions identified 4 years earlier developed into an ulcer with an uncommon shape. The patient has been treated in outpatient oncological and dermatological care with oral and topical antibiotics and disinfectants without clinical improvement. The patient had three biopsies from this region. A histopathological examination of the skin specimen revealed ulceration with substantial inflammatory infiltration and epithelium hyperplasia with a presumably reactive dysplasia.

In the dermatological history, the patient had excessive keratosis two years before admission and two months later showed subcuticular capillary haemangioma, acanthotic epidermis hyperplasia and inflammation. One year before the admission, pseudo epithelial hyperplasia was examined.

During the hospitalization the differential diagnosis considered *dermatitis artefacta*, *pyoderma gangrenosum*, basal cell carcinoma, and *tuberculosis cutis*. Laboratory tests revealed leukopenia, neutropenia, microcytic anaemia and increased CRP (72 mg/dL, N: < 3 mg/dL). Bacteriological examination showed *Staphylococcus aureus* (*S. aureus*) MSSA ++ (with no drug resistance). Colonisation with MSSA is very common with studies reporting rates of 39% in emergency department patients [2], 76% in patients with skin and soft tissue infections [3] and 70% in individuals with community-associated staphylococcal skin and soft-tissue infections [4]. The methicillin-sensitive *S. aureus* colonization was not associated with greater odds of disease [5].

The systemic treatment with ciprofloxacin, topical antiseptics and sulfathiazole ointments were introduced. Furthermore, hydrophobic silicate plasters and hydrogel wound dressings were applied to heal the ulcer. What was crucial, it prevented the patient from manipulating the

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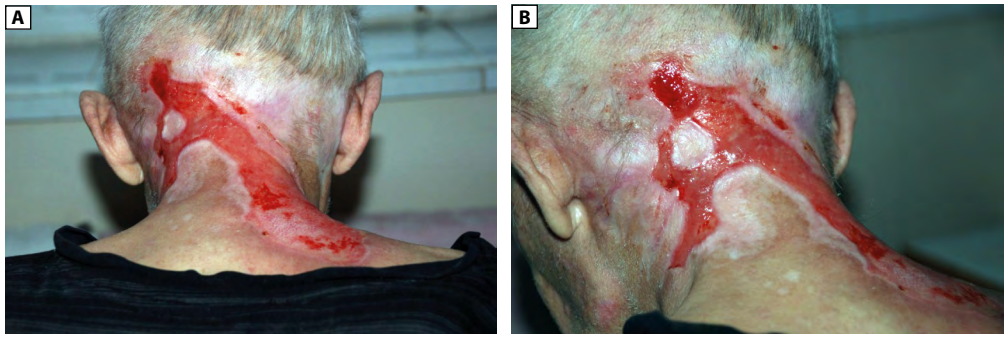

Figure 1. The patient during admission to the clinic; visible large shallow ulceration of a bizarre shape on the neck and occipital region

lesion. Due to other hospitalized relations, the right-handed patient had often touched the affected area. This combined therapy with changing the wound dressings frequently resulted in fast clinical improvement. What is interesting, the post-stroke patient had right-hand paralysis, but either way was able to cause the ulcer by manipulating.

The results of the third biopsy with non-specific dermatosis, along with the patient's manipulation within the skin lesion and great improvement after its occlusion led us to the diagnosis of dermatological factitious disorder.

DISCUSSION

Skin, the most external organ of the human body, is also the most vulnerable to self-induced damage. Self-induced dermatoses are very common, especially during adolescence and young adulthood, which could be associated with excessive and inappropriate skincare. They involve about 2% of dermatology patient visits and include factitious disorders without registered pathological behaviour and compulsive disorders with ascertained pathological behaviour [6].

Otherwise, the self-induced skin lesions can demonstrate the physical and psychological reaction to stress and sympathetic response. Sometimes, scratching can relieve and help people cope with difficult emotions. There is a handful of potential causes of self-induced dermatoses. It could be a means of regulating emotions or a response to other psychiatric factors — such as body dysmorphic disorder, somatic symptom disorder and borderline personality disorder. Alternatively, a patient could have intentionally induced this sickness for any reason. Lesions induced in both ways can be mistaken as primary dermatological diseases or coexist with them, which makes it even harder to differentiate [7, 8].

Factitious disorder is characterized by the conscious production of symptoms without apparent external incentives. It is important to distinguish factitious disorder from malingering, which involves the intentional production of symptoms for external gains.

CONCLUSIONS

Dermatological factitious disorder can be presented as different skin lesions, on this account it can be mistaken for other common diseases. It most often coexists with a mental aberration or puerile personality. Appropriate anamnesis and histopathology are crucial parts of the diagnosis. The proper treatment consists of psychotherapy, antidepressants and antipsychotic drugs.

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Author contributions

Writing original draft, review and editing, conceptualization — MO; writing original draft, review and editing — EM; writing original draft — PL; supervision, review and editing — AB; supervision — IF.

Conflict of interest

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