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Dermatitis artefacta: a challenging diagnosis

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Dear Editor,

Dermatitis factitia (DF), also known as dermatitis artefacta, is a rare condition characterized by self-inflicted skin lesions.[1] These lesions can be a result of compulsive habits driven by emotional distress, serving as a means of emotional release during episodes of anxiety or distress.[1] Alternatively, they may be deliberately induced by the patient with the intention of gaining medical attention.[1] DF is essentially the physical manifestation of underlying psychiatric disorders, making it a particularly challenging condition within the realm of medical practice.[2] Being a diagnosis primarily based on the exclusion of an underlying disorder often requires multiple investigations that can impose a significant economic burden.[3]

We present the case of a 70-year-old woman who came to our attention with skin lesions located on her left cheek, left eyebrow, and forehead, which were present for approximately two years. The patient had a medical history of arterial hypertension, diabetes, and anxious depressive syndrome, for which she was receiving treatment with duloxetine (60 mg daily) and alprazolam (0,25 mg three times daily). On physical examination, the lesions appeared as erythematous and crusted plaques with irregular margins, slightly infiltrated, and were reported as itchy and painful by the patient (Figure 1 a,b). These lesions had proven resistant to topical antibiotic therapy previously prescribed by another physician. Subsequently, we ordered a comprehensive hematological diagnostic assessment, including blood count, C- reactive protein (CRP), Erythrocyte sedimentation rate (ESR), antinuclear antibodies (ANA), extractable Nuclear Antigen Antibodies (Anti-ENA), C3, C4, protein electrophoresis, rheumatoid factor, quantiferon, angiotensin-converting enzyme test, Thyroid-stimulating hormone, glycaemia, glycated hemoglobin, aspartate aminotransferase, alanine aminotransferase, creatinine, and gamma-glutamyl transferase. We started treatment with emollient. During her second visit to our department after a month, the patient provided her blood test results, which were normal, except for an elevated ESR (25 mm/hr). We recommended a skin biopsy with histological examination and direct immunofluorescence to investigate the possibility of connectivitis, pseudolymphoma, or cutaneous sarcoidosis, which the patient declined. She additionally reported an increase in the dosage of alprazolam (0,50 mg three times a day), prescribed by her psychiatrist for managing her anxious-depressive syndromes. Unexpectedly, after the alprazolam dosage was raised, there was a noticeable improvement in the facial lesions within five months (Figure 1 c,d). However, a persistent erythematous area on the chin remained. Initially, the patient mentioned using tweezers to extract white hair. Upon additional questioning, she revealed that, in the past, she had consistently used tweezers on her face at the level of the previous lesions for hair removal. Notably, the compulsive hair removal behavior decreased and ultimately ceased following the dosage adjustment of her anxiolytic therapy, leading to the resolution of the

skin manifestations. Considering the patient's clinical history, lesion characteristics, her reported compulsive use of tweezers on her face, and the improvement following optimization of anxiolytic therapy, we established a diagnosis of self-induced dermatitis factitial.

The pathological fiction of illness is found in all medical disciplines, with a variety of manifestations ranging from self-inflicted injuries to unnecessary interventions and repeated hospitalizations.[2] The patient's motivations and intentions, as well as the severity of manifestations and psychological correlates, vary widely. The ICD-11 currently defines artifactual skin disorders as a range of self-inflicted skin injuries that are provoked by mechanical means or by the application or injection of chemical irritants or caustics.[4] The true prevalence of these conditions is unknown, given its rarity and difficult diagnosis, but it is more frequently observed in females.[5] Timely diagnosis of DF is essential to minimize the use of healthcare resources and mitigate potential harm to patients.[4] Early intervention in the management of DF can also contribute to improved patient outcomes. The clinical and demographic characteristics of individuals affected by DF remain poorly defined.[4] Most available literature on DF primarily comprises case reports and series, which, while important sources of information, may offer an incomplete clinical perspective of the disorder.[3] A careful examination of skin lesions can raise suspicion, particularly when they exhibit atypical features.[5] However, solely observing these lesions may not always be sufficient to suspect dermatitis factitia, as exemplified in our clinical case. Artefactual dermatitis should always be considered in the differential diagnosis of chronic, problematic, and recurrent skin disorders, particularly in patients who have psychiatric problems or specific psychological traits.[6-8] When dermatitis presents with crusted lesions, it may be challenging to differentiate it from conditions like ecthyma and herpes simplex. In other instances, it can mimic photo-induced connectivitis, cutaneous sarcoidosis, vasculitis, and cutaneous lymphomas. In conclusion, DF continues to be a diagnosis of exclusion, necessitating appropriate investigations to rule out potential mimicking diseases.[4] Apart from the imperative need for an early diagnosis, establishing a coordinated treatment plan between the dermatologist and the psychiatrist is another crucial element in addressing FD effectively.

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Figure 1. a, b) Skin lesions located on her left cheek, left eyebrow, and forehead, that were present for approximately two years; **c, d)** resolution of skin lesions after increasing the dosage of alprazolam for managing her anxious-depressive syndromes.