Patient

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Dermatitis artefacta

Synonyms: factitious dermatitis, factitial dermatitis

What is dermatitis artefacta?[1]

Dermatitis artefacta is an intentional self-inflicted dermatitis that is difficult to diagnose and treat effectively.[2] There may be an unconscious compulsion based on psychological or emotional need to elicit care.

The patient will very often deny self-infliction and the diagnosis doesn't include self-mutilation, such as multiple superficial cuts to the skin. See also the article on Self-harm. The diagnosis also does not cover lesions made by others, such as cigarette burns (as may occur in child abuse).

Lesions may be produced by a variety of mechanical or chemical means, including fingernails, sharp or blunt objects, burning cigarettes and caustic chemicals.

There are some circumstances in which the application of the diagnosis may be debated:

- In neurotic excoriation what seemed at first to be normal skin is scratched. It is inappropriate to refer to imaginary itch, as itch like pain is a subjective sensation. The excoriation sets up a reaction in the skin that makes it itch more and a vicious circle is produced. Itching may be produced in a healthy skin by neurological disease.
- Similarly, trichotillomania is usually a neurotic habit where individuals deep in concentration, wrap their hair around a finger and pull it tight causing hair loss.
- Formication means a sensation like ants running on the skin and causes sufferers to itch and claw at their skin. It can occur with alcohol and amfetamine abuse and some forms of psychosis. Delusional parasitosis may also occur.

How common is dermatitis artefacta? (Epidemiology)

- The condition is considered to be uncommon, but diagnosis is frequently uncertain and many times not even considered, and therefore the true prevalence is unknown.[3]
- Dermatitis artefacta is thought to account for between 1 in 200 to 1 in 2,000 dermatological consultations.[4]
- It is more common in women (male to female ratio of at least 1:4) and has a broad and variable age of onset (9-73 years), with the highest frequency during adolescence and young adulthood.[5]

Risk factors

- It is reasonable to assume that this condition represents a psychological abnormality although the patient may not be known to have a psychiatric illness. Co-existing psychiatric disorders are wide-ranging and include anxiety, depression, personality disorders, psychotic illness and dissociative disorders.
- Stress and post-traumatic stress disorder (PTSD) may be involved.[6]
- There is a strong association with eating disorders - the condition occurring in approximately a third of patients with anorexia or bulimia.[7]
- Onset or relapse of dermatitis artefacta is often precipitated by definable psychosocial stressors, varying according to age and life situations.
- Many patients also have an associated chronic medical or dermatological condition.

Dermatitis artefacta symptoms (presentation)

The clinical presentation is very variable depending on the mode of injury used - eg, fingernails, sharp or blunt object, or chemicals. It can range from mild excoriations, abrasions, and blisters to deep ulcers and burns.[3]

History

A detailed history should be elicited; however, it may feel 'hollow', contradictory and elusive in nature:

- The skin lesion is usually described as appearing overnight with no evolution of signs or symptoms. However, patients may also reveal a 'special' ability to predict when and where a new lesion will appear, preceded by subjective symptoms of heat, burning, or other abnormal sensations.
- If challenged, the patient will usually deny that the rash is self-induced or change their story if confronted with inconsistencies.
- Enquire regarding past medical history (eg, chronic medical conditions, chronic pain syndromes), psychiatric history and substance abuse.
- Determine whether there is a past history of child or sexual abuse or trauma.
- Note whether there are any significant psychosocial stressors.
- Explore with the patient the impact of the condition on his/her quality of life; discuss what his/her own perception of the skin condition is. Ask how family members react.
- Occupational history: note whether the patient or a close contact of the patient has worked in the healthcare system.
- Check collateral histories where available.
- Check whether medical records are extensive, indicating numerous contacts, hospitalisations and procedures.

Examination

- Lesions can be enormously variable in character, depending upon how they are produced but often what is presented is quite florid. The doctor may be quite shocked whilst the patient is remarkably unperturbed with 'la belle indifference' (or 'Mona Lisa' smile of innocence) that is typical of hysterical illness.
- The range of lesions includes red patches, swelling, blisters, denuded areas, crusts, cuts, burns, and scars and there may be more than one type of lesion.[8]

- They are often in bizarre shapes with irregular outlines in a linear or geometric pattern.
- There is usually clear demarcation with normal skin around the lesions.
- They are usually found on sites that are readily accessible to the patient's hands, such as face, hands, arms or legs but not in inaccessible areas such as between the scapulae. They may predominate on the patient's non-dominant side.

Investigations

There is no investigation that is specific for the disease. Swabs may be taken if secondary infection is suspected. If applicable, tests may be used to exclude other diseases such as skin biopsy. There is almost certainly some psychiatric pathology that will merit investigation at some stage.

Differential dermatitis artefacta diagnosis

They may resemble many other lesions but the classical features of dermatitis artefacta include:

- Clearly circumscribed lesions with normal intervening skin.
- A geometrical or other pattern that is rarely seen in organic disease.
- Lesions confined to areas of easy access by the patient.

Linear lesions may follow trauma due to Köbner's phenomenon which usually affects psoriasis, lichen planus and occasionally erythema multiforme. Dermatitis artefacta can mimic a multitude of different skin disorders. These include:

- Basal cell carcinoma.
- Pyoderma gangrenosum.[9]
- Cutaneous T-cell lymphoma.[10]
- Cutaneous vasculitis.[11]

An important differential diagnosis is malingering in which the patient is consciously aware of producing factitious lesions, the purpose being to avoid work or claim compensation.[12]

Dermatitis artefacta treatment and management[3] [13]

- Early consideration of the diagnosis is important to avoid unnecessary and potentially harmful investigations and treatments.[7]
- Management may be difficult and long-term treatment is often required.[14]
- Management is usually shared between dermatologists, psychologists and psychiatry.[15]
- Most patients need some form of specialist psychiatry assessment.
- Many advocate avoiding direct confrontation. it is hoped that close supervision and symptomatic care of skin lesions will lead to a doctor-patient relationship in which psychological issues may gradually be introduced. Regularly review suicide and self-harm risk.
- Palliative dermatological measures such as occlusive bandages, ointments or placebo drugs, as well as admission to hospital that includes bathing and massaging by nurses, can have a therapeutic impact on the psychiatric problem by symbolising the medical attention and care for which the dermatitis artefacta patient is craving. Improvement of lesions under protective dressings is supportive of the diagnosis.
- Antidepressants may be of value. Selective serotonin reuptake inhibitors (SSRIs) are often preferred, although the tricyclic antidepressants may have some antipruritic effect and sedation can be beneficial.
- If the patient is motivated, cognitive behavioural therapy (CBT) may be helpful as part of a package of care, although evidence is currently lacking. Atypical antipsychotics such as olanzapine may also be helpful. Inevitably, patients with different psychiatric illnesses require different approaches.

Complications

- Disfiguring scars on highly visible parts of the body, often the face.
- Psychiatric comorbidity, increasing risk of suicide.
- Iatrogenic side-effects from investigation and treatment.

Prognosis[13]

Resolution of the current underlying psychological problem or stressors facilitates a cure for the time at least but dermatitis artefacta tends to be a chronic condition that waxes and wanes with events in the patient's life. Ongoing, intermittent review is often recommended but many patients are often lost to follow up.

Further reading

- Dermatis artefacta; DermNet NZ
- Chandran V, Kurien G; Dermatitis Artefacta. StatPearls, July 2022.

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