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Case Report

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# Sexual violence as a possible trigger in a case of dermatitis artefacta

## Abstract

Dermatitis artefacta (DA) is an uncommon diagnosis made by exclusion. Here, it is depicted a case of a woman that started to mutilate herself with a heated spoon, whenever she felt sexual desire. This self-inflicted aggression begun few months after she was sexually abused.

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Lima LSC,[1] Villa RT,[1] Yamaguchi EM,[2] Tranquillini G,[3] Zorzetto IFH,[3] Hostalácio GFF,[3] Silva TA[3]

[1]Federal University of Maranhão, Brazil
[2]Federal University of São Paulo, Brazil
[3]UFMA, Brazil

**Correspondence:** Ricardo Tadeu Villa, Professor UFMA, Federal University of Maranhão, Brazil, Email ricardovilladermato@hotmail.com

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## Introduction

Dermatitis artefacta (DA) is a rarely diagnosed disorder that is often a source of perplexity and anxiety for dermatologists, because they know less about the cause of this self-inflicted condition than the patients themselves.[1] In this context, it is important to define some terms, like pathomimia cutis, when the injury, or multiple injuries, are intentionally caused, usually using caustic substances or sharp objects. Particularly In cases in which patients hide self-aggression from the doctor, this situation represents Munchausen Syndrome, and usually the patient defies the diagnostic capacity of the professional. On the other hand, when patients do not voluntarily inform about the self-agression, but when questioned, recognizes it, it is called DA, as in this case report.[2]

## Case report

A 38-year-old woman, single and childless, presented to the Dermatology service of Federal University of Maranhão, Brazil, with multiple ulcerative lesions on the breasts and thighs. At the time of the visit, the patient was in good general condition, but suspicious and avoiding eye contact. She denied having any systemic diseases. On physical examination, there was no evidence of insect bite, any allergy or infection and her lesions had an oval shape and were in different stages of healing (Figure 1). They were not typical of any known dermatological disorder. When asked if there were any previous injuries, the patient denied it.

A complete laboratory evaluation was performed, including complement components level, C-reactive protein, erythrocyte sedimentation rate, blood count, c-ANCA, p-ANCA, antinuclear antibody, renal and hepatic function tests, hepatitis C, B, and HIV serology. They were all within normal range. Additionally, completing the investigation, a skin biopsy was performed, and the findings of histological examination were non-specific, exhibitinga chronic inflammatory process, involving epidermis and papillary dermis. Finally, there was nobacterial or fungal growth in culture.

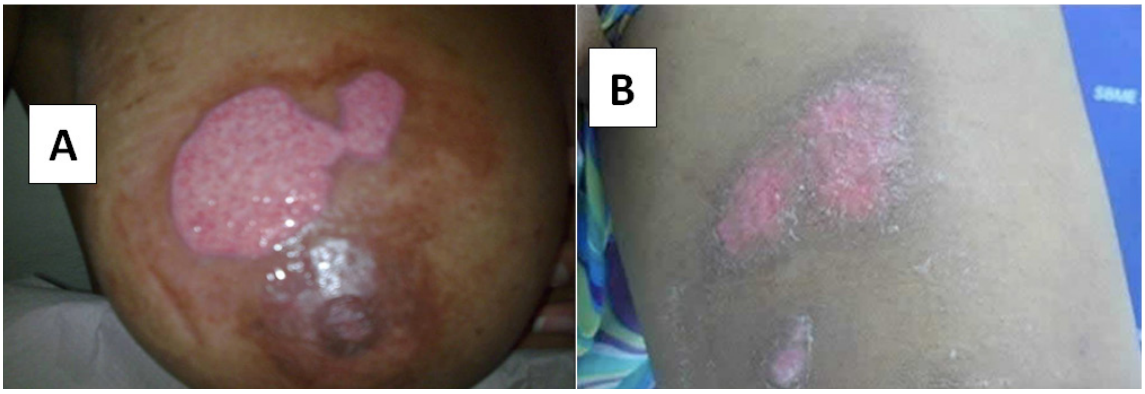


**Figure 1** (A) Breast with recent wound (B) left thigh with almost healed ulcer.

Surprisingly, when the patient returned to remove the stiches, she told the nurse that her injuries were self-inflicted and that she was feeling guilty for not telling the truth, before she underwent this thorough investigation. Further, she mentioned she started to mutilate herself with a heated spoon, whenever she felt sexual desire, and these episodes started about a year ago, right after she was sexually abused by her neighbor. During her outpatient follow-up, she revealed that, after this episode of violence, she started feeling anxious and afraid,

with difficult to socialize and repulsion to men. In the beginning, she burned her own genitalia, however she said that "as it hurt so much in that place (genitalia), I started to burn a place nearby: my thigh". Moreover, she said that she "felt guilty for having sexual desires and, therefore, should be punished", and "the pain helped to cope with guilt".

In order to offer a better follow-up, the patient was referred to the psychiatric service and immediately started a cognitive-behavioral therapy. However, she refused to receive any medication, including serotonin reuptake inhibitor, suggested by the psychiatrist. After two months, the old lesions presented a good response to occlusive dressing, though, the patient continued to make new lesions. Ultimately, after she was informed again about the importance of multifocal treatment and once more referred to the psychiatric service, she abandoned her follow-up.

## Discussion

The first case of DA was published by Azúa in 1909.[3] After studying four cases of women with "hysterical gangrene", he confirmed that only one case had hysterical origin, while the other three cases were defined as self-inflicted lesions. In fact, there are few cases reported in literature and most authors report isolated cases to portray clinical presentation and diagnostic difficulties.[4] Thus,DA true prevalence is unknown, though the majority of cases occur around 20 years, being more common in women (in contrast, Munchausen syndrome is more common in men). It is worth noting that DA is present not only in Dermatology services and, in fact, 5% of the consultations in all medical specialties are believed to be due to factitious diseases.[5]

Clinically, the injuries can have different aspects and configurations. Ulcers, with regular or irregular edges, with unusual shapes, are the most common lesions in most series, either in early stages of development or after healing, when they leave pigmented scars. They are almost always in areas within the reach of the hands, however, lesions in areas inaccessible does not rule out the hypothesis of self-injured comportment. The shape of the lesion usually suggests the mode used for self-aggression.[6]

DA is a challenging diagnosis due to the wide variety of resources and devices used by patients for self-aggression, and, besides, it is necessary to exclude other dermatological conditions.[7] It is crucial that the doctor does not lose the opportunity to observe the patient's behavior from the very beginning of the first consultation, and typical manifestations would include: anxiety, agitation, lack of facial expressions, or even excessive calm. Beyond that, patient may avoid eye contact or be indifferent and non-collaborative.[1] During the interview session, constant rubbing or picking of the lesions with a Mona Lisa smile is not uncommon.[5]

It is important to mention that, since lesions are made by the individual to satisfy a psychological need, often a desire to receive medical treatment, laboratory analysis, as well as, histopathological examination are nonspecific, and they just can exclude other illnesses.[8] That said, in the face of a suspicion of DA, one possible approach consists in investigating possible triggers, like change in social and economic position, concerns about self-image, history of sexual abuse, loss of a loved one, problems in relationships (usually with family members), bipolar or obsessive-compulsive disorder, and even substance abuse.

Concerning the investigation, another possible "clue" is social reclusion. Since the lesions can cause significant damage to the skin, and 45% of patients hurt their own face, there are reports of isolation and avoidance of social events and patients even quitting their job or college. Aesthetic impairment results in image and personality disorders.[8,9]

As DA is a somatic condition, the diagnosis should be made considering psychological and dermatological factors and it is necessary to evaluate the morphology of the lesions, the patient's personality and medical history. According to the latest update of Diagnostic and Statistical Manual of Mental Disorders (DSM-V), diagnostic criteria of DA are: recurrent skin picking resulting in skin lesions, repeated attempts to decrease or stop skin picking, the skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, the skin picking is not attributable to the physiological effect of a substance or another medical condition, the skin picking is not better explained by symptoms of another mental disorder.[10]

The main differential diagnosis of DA is neurotic excoriation. However, in neurotic excoriation, patient does not try to hide the fact that the lesions are self-inflicted and excoriations are done habitually with the nails, while in DA objects and substances are used.1Another important differential diagnosis is Munchausen Syndrome, characterized by multiple symptoms and lesions that are not limited to the skin. Malingerers inflict injury on themselves for some secondary gain and this act is considered a crime, since malinger is not mental illness.[5]

Additionally, considering eminently dermatological diseases, one should rule out necrotizing vasculitis, gangrenous pyoderma and cutaneous T-cell lymphoma.[9] These conditions exhibit, besides a suggestive clinical presentation, a typical histopathological aspect, whereas DA histopathological features are non-specific and, usually, it has characteristics of acute, but mild inflammation with increased polymorphonuclear leucocytes and scattered erythrocytes. Areas of necrosis with areas of healing and fibrocystic reaction may also occur.[11]

The treatment of DA is often unsatisfactory, whether it is managed by a dermatologist, a psychiatrist, or both. Initially, psychotherapy should be suggested, preferably cognitive behavioral therapy and selective serotonin reuptake inhibitor antidepressants can be prescribed, in order to potentiate non-pharmacological approach. Available studies show that no single drug is superior to others, but higher dose range of selective serotonin reuptake inhibitors (SSRIs), or low-dose atypical antipsychotic agents may be effective for treating dermatitis artefacta. Particularly, SSRIs such as escitalopram and fluvoxamine are found to be effective in reducing symptoms of dermatitis artefacta and sertraline has been found to be effective in reducing excoriations in open trial.[12]

As for dermatological treatment, moisturizers and emollients, as well as antibiotics (in case of secondary infection), can be used. However, the most effective treatment directed to the skin is occlusion of the excoriated sites.[13]

## Conclusion

DA diagnosisis a hard puzzle to assemble, taking into account its rarity, vague history, bizarre morphology, and absence of decisive diagnostic tests. Additionally, treatment is also a great challenge and, even when a good doctor-patient relationship is established, the outcome can be frustrating, as seen in this case.

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## Conflicts of interest

We declare no conflict of interest.

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