

# A case of dermatitis artefacta: Clues which help early diagnosis

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A 26-year-old married female presented with a complaint of recurrent multiple ulcerative lesions on her body. After complete history and physical examination, a diagnosis of dermatitis artefacta was made. Dermatitis artefacta remains undiagnosed for quite some time because of its atypical skin changes, diverse methods used for producing skin lesions, lack of awareness about the disorder on the part of physicians, nonspecific histology, and normal blood tests. An early and correct diagnosis is helpful in avoiding unnecessary investigations, and allowing better patient management. In this particular case, there were three important clues (medical history, morphology of the lesions, and the patient's behavior) which paved the way for an early diagnosis of this rather puzzling and rare disorder.

**Keywords:** dermatitis artefacta, psychocutaneous disease, *la belle indifférence*

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## INTRODUCTION

Dermatitis artefacta is a rare but well recognized psychocutaneous disorder characterized by self inflicted lesions for which the patient denies any responsibility<sup>1,2</sup>. Dermatitis artefacta is a frustrating disease for both the physician and the relatives as it is difficult to establish the role of the patient in the development of the lesions. An expert eye is needed to establish a diagnosis of dermatitis artefacta because the pattern of skin lesions is variable depending on how it is caused. We report a case of dermatitis artefacta to highlights the importance of various clues in patient history and examination to make an early diagnosis.

## CASE REPORT

A 26-year-old housewife was visited in the Skin Outpatient Department with multiple bizarre shaped ulcerative lesions over the abdomen (Figure 1). The ulcers had appeared 10 days earlier and were now in various stages of healing. Few

ulcers had a necrotic base, mild crusting, and an erythematous border. The surrounding skin was inflamed and painful. Various patches of mottled pigmentation post healing were present on the abdomen. A single geometrical superficial erythematous erosion with a sharp edge was present on the flexural aspect of left forearm (Figure 2). On first look, a clinical diagnosis of pyoderma gangrenosum was suspected. A complete cutaneous examination was done which revealed keloids on the left breast (Figure 3) that were preceded by



**Figure 1.** Multiple bizarre shaped ulcerative lesions on the abdomen.



**Figure 2.** A well-defined geometrical erosion on left forearm.



**Figure 3.** Multiple keloids on the left breast.

ulcerative lesions 3 months earlier and healed after prolonged treatment. Few hyperpigmented patches of previous healed ulcers were present on legs.

The patient gave a history of excruciating pain in lesions, sero-purulent discharge, and rapid progression of the lesions. There was no history of trauma or burns. On query regarding the origin of the lesions, the patient stated that the lesions were spontaneous in onset and were preceded by an itching and burning sensation 6 to 8 hours before the development. She was an alert, calm, cooperative married female with two children. There was no history suggestive of any marital discord.

Past history revealed similar episodes of sudden development of ulcers on arms and legs. There was a history of multiple hospital admissions and referrals in the past for vague complaints of chest pain and discomfort for which no specific cause could be ascertained.

We finally concluded that the skin lesions did not confirm to any specific dermatological disorder and were present only on accessible areas of the body. There was also an ambiguous history regarding their development. Despite complaining about severe pain, the patient was surprisingly calm and had a smiling face.

Investigations revealed a normal CRP, ASO titer, ESR, and chest X ray. The swab culture from the lesion was sterile. The report of skin biopsy was nonspecific showing hyperkeratosis, hyperplasia along with elongation of rete ridges, and a mild increase in the granular layer. The subepithelial tissue showed vascular proliferation along with perivascular lymphocytic infiltration with occasional eosinophils. Considering all these factors, a provisional diagnosis of dermatitis artefacta was made. She was put on oral and topical antibiotics and was advised to be hospitalized if new lesions appeared.

On the next follow up after 10 days, abdominal lesions showed healing but similar new sharply defined erythematous superficial lesions were present on the left forearm along with U and L shaped lesions over an urticarial base on the upper back (Figure 4). She was admitted to the skin ward for further management. During 4 days of hospital stay, the existing lesions were covered with occlusive dressing and the patient was closely monitored. Although the previous lesions showed signs of healing, there was a single bruise on her left



**Figure 4.** U and L shaped lesions on the upper back.

arm overnight (Figure 5). The patient was finally confronted about her role in the development of the lesions which she denied.

At this stage, a psychiatrist's opinion was



**Figure 5.** Bruise on the left arm.

requested which revealed a borderline personality disorder. The patient was discharged and advised to seek regular psychological counseling and psychiatry follow up but she was lost to follow up.

## DISCUSSION

Dermatitis artefacta is a psychocutaneous disease classified as a factitious disorder. It has a prevalence of 0.05% to 0.4% with a marked female preponderance (male to female ratio: 1:4 to 1:8)<sup>3,4</sup>. According to the Diagnostic and Statistical Manual of Mental Disorders, the diagnostic criteria of dermatitis artefacta include the intentional production or feigning of physical or psychological signs or symptoms, the motivation for the behavior being the psychological need to assume the sick role, and the absence of external incentives<sup>5</sup>. The most common lesions in DA are excoriations, ulcers, blisters, eczematous lesions, and rarely panniculitis<sup>2</sup>. The lesions may be produced by a variety of mechanical or chemical means including sharp or blunt objects, fingernails, caustic chemicals, hot metal objects, and burnt wood<sup>4</sup>.

In this particular case of DA, the lesions appeared dubious from the very beginning. Multifaceted, well demarcated lesions including ulcers, keloids, superficial erosions, eschars, and bruises were developed over a period of six months. Multiple sites were involved, including the breast, upper back, abdomen, left forearm, and left leg, although lesions were predominantly on the left side and exclusively on accessible areas of the body in our right-handed patient.

The atypical morphology of the lesions was the first diagnostic clue in this case. Another important diagnostic indicator was the calm demeanor of the patient. Her characteristic *Mona Lisa smile* of innocence was overtly noticeable<sup>6</sup>. She always seemed pleased to display her lesions and never asked for any analgesics despite complaining of extreme pain. This is a remarkable characteristic in DA patients when they have a calm attitude without emotional involvement called *la belle indifférence*<sup>7</sup>.

The patient could never give a clear account of the origin of her lesions. The vague melodramatic complaints of a burning sensation hours before the development of lesions and the hollow history added weight to our diagnosis. Furthermore, in the

hospital setting when she was under observation and given occlusive dressing over the lesions, a single ecchymotic patch developed on her left arm suspected to be due to blunt injury, but no new well-defined ulcerative lesions developed while the earlier ulcers showed signs of healing.

In the first visit, the patient was not confronted about the self-inflicted nature of her lesions, as it could result in abrupt termination of treatment in the beginning. In our patient, the psychiatry consult was sought at a later stage but she still denied her role in of the development of the lesions and abandoned treatment. Although a psychiatric consultation forms an inevitable part of the management of dermatitis artefacta, it should be done only after an adequate patient-physician relationship has been established. Direct confrontation of the patient in the initial visits should be discouraged as it results in loss to follow up.

Dermatitis artefacta is a difficult and rare diagnosis. It requires keen observational skills on the part of the dermatologist along with careful and detailed history taking skills. We would like to emphasize the use of three important diagnostic clues (medical history, morphology of the lesion, and patient's behavior) in making an early diagnosis

of DA. Increased awareness and early diagnosis of DA can prevent patient repetitive visits and help with better patient management.

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