

RESIDENT ROUNDS: PART II

Common Psychodermatologic Disorders

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INTRODUCTION

Psychodermatologic disorders are prominent in any dermatology practice – be it general, pediatric, or cosmetic dermatology. They can be extremely challenging to manage. In all cases, organic dermatologic illness must be ruled out. We provide a review of the commonly encountered psychodermatologic disorders to aid with proper diagnosis and management of this population. This review can also be used as a reference for board preparations.

Table 1. Common Psychodermatologic Disorders

Disorder	Introduction	Clinical Findings	Management
Delusions of Parasitosis	Fixed false belief of an infestation with parasites, in the absence of any objective evidence of infestation. Patients often function well in other aspects of their lives. Formication: Report cutaneous sensations of "bugs" crawling on or under skin. *Must distinguish from substance-induced formication (alcohol withdrawal, amphetamines, and cocaine). Matchbox sign: Patients will often bring pieces of skin, lint, and other samples that they believe represent "parasites" to an office visit in plastic wrap or matchboxes. Folie à deux ("craziness for two"): Family members and other co-habitants share the patient's delusion.	Range from none at all to mild excoriations, prurigo nodularis, and/or frank ulcerations.	Build trust with the patient, which will usually require several visits. Referral to a psychiatrist is often warranted, but many patients will resist psychiatric consultation. Treatment: Antipsychotic medications such as pimozide (older treatment – more evidence, but more side effects: extrapyramidal side-effects and prolonged QT interval) or newer atypical antipsychotics such as risperidone.
Body Dysmorphic Disorder	Excessive preoccupation over a non-existent or slight defect in appearance with large amounts of time spent inspecting the area. Frequent body sites of concern: nose, mouth, genitalia, breasts, or hair. Often begins in early adulthood.	Objective evaluation will reveal a normal appearance or slight defect.	Spectrum of disorder ranges from obsessions (preoccupation with perceived inadequacies), which fall within obsessive compulsive disorder (OCD) spectrum to delusions (fixed false beliefs about their appearance), which fall within the psychotic spectrum. Treatment: Selective serotonin reuptake inhibitor (SSRI) if OCD variant; antipsychotics if delusional variant.

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Dermatitis Artefacta (Factitial Dermatitis)	Patients self-induce skin lesions in order to satisfy an unconscious psychological or emotional need. *Should be differentiated from malingering, in which lesions are created deliberately for conscious gain, such as collecting disability or evading prosecution. Patient typically denies creating the skin lesions. Women > men.	Variable lesion morphology, but clue to diagnosis is unusual shapes, particularly angulated edges.	Wound care to help with healing. Treatment: May need antidepressants, antianxiety medications, or antipsychotic medications.
Neurotic Excoriations	Conscious, repetitive, and uncontrollable desire to pick, rub, or scratch the skin, often at sites of pre-existing lesions. *Unlike patients with dermatitis artefacta, those with neurotic excoriations will usually admit their involvement in creating the lesion. Acne Excoriée: Subset of neurotic excoriations in which patient compulsively picks their acne lesions. More common in middle-aged women.	Lesions at various stages typically distributed within reach of the dominant hand (extensor surfaces of the arms, scalp, face, upper back, and buttocks).	Treat underlying cutaneous disorder (eg, folliculitis, acne). Treatment: Antihistamines (ie, doxepin) for pruritus,+/- SSRIs to decrease OCD manifestations.
Trichotillo-mania	Obsessive-compulsive disorder where patient pulls out own hair (scalp, eyebrow, pubic hair), leading to alopecia. May be associated with nail biting, thumb sucking, or poor school performance. Histology: empty anagen follicles; deformed hair shafts (trichomalacia); pigmented hair casts. More common in young females.	Irregularly irregular hairs: Hairs of varying length distributed randomly within areas of alopecia. Lack findings associated with other alopecia's such as scarring, exclamation hairs, or nail pitting.	Behavior modification therapy is first line treatment. Treatment: SSRIs have been shown to be helpful.

DISCLOSURES

None of the authors has declared any relevant conflicts of interest.

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