Dermatology. **Lecture: 6**
Dr. Intisar Ahmed **Stage: 5**

Psychocutaneous Diseases

*Psychodermatology" refers to any aspect of dermatology in which psychological factors play a significant role.
*Many patients with psychodermatologic problems resist referral to a mental health professional, and some become upset if such a referral is suggested to them.

Classification of psychodermatologic conditions:

●psychophysiologic disorders, in which a genuine skin disorder, such as psoriasis, is exacerbated by emotional factors.
●primary psychiatric disorders, in which the patient has no primary skin disease and all of the cutaneous findings are self-induced, such as in delusions of parasitosis.
●secondary psychiatric disorders, in which the patient develops psychological problems as a result of a skin disease that causes physical disfigurement, as in vitiligo or alopecia areata.
●cutaneous sensory disorders, in which the patient presents with a purely sensory complaint, such as pruritus, burning or stinging, without visible evidence of primary skin disease or a diagnosable underlying medical condition.
●the use of psychotropic medications for purely or primarily dermatologic conditions, such as administration of doxepin to treat chronic urticaria or amitriptyline for postherpetic neuralgia.

Delusions of Parasitosis:

False and fixed belief that they are infested by parasites, in the absence of any objective evidence of infestation.
*The average age of onset is in the **50s to 60s.**
*Women twice as men.
*Typically present with a history of symptoms for months or even years.
*Evaluated by many physicians and use many treatment modality.
*The patients frequently bring in bits of skin, lint and other samples that they believe represent "parasites" which is referred to as the "**matchbox sign**".

*They report cutaneous sensations of crawling, biting and/or stinging.
*Skin findings range from none at all to excoriations, lichenification, prurigo nodularis and/or frank ulcerations.
*All of these are self-induced, often resulting from the patient's efforts to dig out "parasites".
*Management: Antipsychotic medication (pimozide).

Body Dysmorphic Disorder:

Preoccupation with a non-existent or slight defect in appearance.
*May affect as many as 10–14% of dermatology patients.
*Often begins in **early adulthood.**
*Male-to-female ratio of 1 : 1.
*Frequent body sites of concern are the nose, mouth, hair, breasts and genitalia.
*Typically associated with compulsive or ritualistic behaviors.
*A subtype of body dysmorphic disorder is **olfactory reference syndrome**, in which affected individuals are preoccupied with that they emit an unpleasant odor, which nobody else can perceive.
*These patients often engage in compulsive behaviors in an attempt to eradicate the perceived odor, such as repetitive showering or excessive use of deodorants, perfumes or mouthwash.
*Management: The first-line therapy is SSRI

Dermatitis Artefacta:

Psychocutaneous disorder in which patients inflict cutaneous lesions upon themselves to satisfy a psychological need of which they are usually not consciously aware.
*Typically located in areas that are easily reached by the hands.
*Although usually within easy reach of the hands, the lesions can be caused by methods such as carving with sharp instruments, applying chemicals and injecting foreign substances.
*The patients deny having any role in creating the skin lesions.
*Clinical features can mimic a wide variety of dermatoses and ranges from vesicles to purpura to subcutaneous emphysema.
*The lesions may be single or multiple and unilateral or bilateral.
*This disorder is often difficult to diagnose and treat, a clue to diagnosis is unusual shapes, particularly angulated edges, that suggest an external method of induction

*Female-to male ratio of 8 : 1.
*__Münchhausen syndrome by proxy__, in which an individual produces lesions on another person in order to satisfy a psychological need that is not consciously recognized.
*Management:
*Wound care
*Primary dermatologic disorder needs to be excluded.
*Antidepressant, antianxiety or antipsychotic.

Neurotic Excoriations:

Repetitive, uncontrollable desire to pick, rub or scratch the skin.
*Most commonly seen in **middle-aged women.**
*The lesions may evolve from a pre-existing urticarial papule or acneiform lesion, or they may be created de novo.
*Repeated picking or rubbing results in excoriations with a variety of shapes (e.g. linear/ angular, circular, oval).
*The distribution is characteristically on the extensor surfaces of the arms and forearms as well as the scalp, face, upper back and buttocks.
*Lesions may range in size from a few millimeters to several centimeters, and several stages of evolution are often evident, from small superficial erosions to deep ulcerations with hypertrophic borders to hypo- or hyperpigmented scars.
*On the scalp, there may be broken hairs as well as areas of scarring alopecia.
*Individuals with neurotic excoriations often have an obsessive–compulsive personality.
*Management:
*Primary cause of pruritus are excluded.
*Treatment of underlying cutaneous disorders (e.g. folliculitis).
* Topical antipruritics: pramoxine or menthol.
*Cool compresses, hydrate the skin, and facilitate debridement of crusts.
*Antihistamines: hydroxyzine can have beneficial sedative and antipruritic effects.
*Intralesional corticosteroids.
*Doxepin: in patients with neurotic excoriations with depression and anxiety.
*If major depression is present, an antidepressant dose.
*Behavior modification, cognitive and psychodynamic therapy.
*The average duration of disease activity is 5–8 years without pharmacologic therapy.

Acne Excoriée:

Subset of neurotic excoriations in which the scratching and picking is directed at acne lesions.
*The underlying acne is often mild but accompanied by extensive excoriations.
*Lesions can become so deep that scarring may occur.
*Most frequently seen in **young women**.
*Management:
*Because acne excoriée is part of the broader spectrum of neurotic excoriations and is often associated with OCD, the treatment is the same as that described above.
*The use of doxepin and SSRIs may be beneficial.
*Aggressive treatment of the underlying acne should be considered.
*Medications such as isotretinoin may be administered.
*However, recurrence of even mild acne may be accompanied by resumption of picking unless the associated psychological disorder is addressed.

Trichotillomania:

Hair-pulling disorder involving scalp, eyebrows, eyelashes or pubic hair.
*More common in **young girls.**
*The classic physical finding is hair of varying lengths distributed within the area of alopecia, with uninvolved areas of the scalp appearing completely normal.
*The hairs are sometimes referred to as "irregularly irregular."
*Lesions are usually single and can be large.
*Plucking may be confined to a specific time of the day and place.
*Some patients practice trichophagy, the chewing and swallowing of the hair that has been pulled out, possibly leading to intestinal obstruction from trichobezoars.
*Hair pulling is one way in which these patients manage their tension.
*In persistent cases, a spectrum of behavioral disorders is frequently encountered, including thumb sucking, nail biting, poor school performance, and dysfunctional peer as well as family relationships.
*Management:
*Difficult and requires a flexible approach.
*Behavior modification therapy is the mainstay of treatment.
This includes self-monitoring, teaching the patients to do something else whenever they are feeling the urge to pull their hair, relaxation techniques and positive reinforcement. *Antidepressants (especially SSRIs).