

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

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CHAPTER 86

# PSYCHODERMATOLOGY AND PSYCHOCUTANEOUS DISEASE

(Part 1)

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# WHAT IS PSYCHODERMATOLOGY?

- 'Psychocutaneous medicine' or 'Psychodermatology' encompasses disease that involves the complex interaction between brain, cutaneous nerves, cutaneous immune system and the skin.
- Most patients with psychocutaneous disease are reluctant to attend purely psychiatric clinic, that's why the sub-specialty of psychodermatology has emerged.

## Skin–psyche interactions may be any of the following:

1. Primarily cutaneous disorders influenced by psychological factors, e.g. psoriasis.
2. Primary psychiatric disease presenting to dermatology health care professionals (HCPs), e.g. delusional infestation, body dysmorphic disorder.
3. Psychiatric illness developing as a result of skin disease, e.g. depression, anxiety or both.
4. Co-morbidity of skin disease with another psychiatric disorder, e.g. alcoholism

## **Box 86.1 Different specialists that may make up the psychodermatology multidisciplinary team**

- Dermatologists
- Psychiatrists
- Psychologists
- Dermatology and other nursing colleagues
- Child and adolescent mental health specialists (CaMHS)
- Paediatricians
- Geriatricians and older age psychiatrists
- Social workers
- Trichologists
- Primary care physicians
- Child and/or vulnerable adult protection teams
- Patient advocacy and support groups
- Others

# 'GOLDEN RULES OF PSYCHODERMATOLOGY

- Psychological stress is an integral cause of skin disease either as an initiating or an exacerbating factor.

## Golden rules of psychodermatology :

1. Exclude organic disease.
2. Appropriately assess and treat the dermatological disease at the same time as appropriately assessing and treating the psychological disease.

The following four discussions of different diseases illustrate the principle.

### 1) ATOPIC ECZEMA :

- Atopic children and adolescents show more anxiety and are provoked to anger more readily.
- Feelings of stigmatization and disfigurement.
- Stress makes atopic eczema worse.

## 2) PSORIASIS :

- Anxiety, depression and suicidal ideation are more common than in patients with eczema, acne or alopecia.
- Depression is significant and may remain undetected.
- Stress can trigger the onset and severity of disease.
- The response to phototherapy in highly worried individuals was almost half that of those who had low worry.

### 3) CHRONIC URTICARIA :

- Significantly associated with depression, dysthymia and anxiety.
- Psychological factors may be prominent at the onset and contribute to disease progression, and negative coping may be associated with exacerbations.

### 4) ALOPECIA AREATA :

- A strong belief that onset and recurrence of alopecia areata is related to stress and major life events .

# STIGMATIZATION

- Situation of an individual who is disqualified from full social acceptance.
- The stigmatized individual is normal until abnormalized by societal views.

Some common situations where stigma may be encountered by patients are :

- Physical visible differences : congenital naevi (e.g. port-wine stain), acquired visible differences such as vitiligo, widespread inflammatory skin disease, surgical or post-traumatic visible differences.
- Behavioral and social factors: Alcoholism and substance misuse, imprisonment.
- Psychiatric disease and learning disabilities.
- Race and religion.

- Self-help and contact with patient advocacy groups can be extremely useful, such as Changing Faces in UK
- Changing Faces is for everyone with a scar mark or condition on their face or body that makes them look different.
- Provides advice, support and psychosocial services to children, young people and adults.

## **Box 86.3 Coping strategies suggested by Changing Faces**

### **3-2-1-Go!**

This prepares a patient with a visible difference with the following coping strategies:

- Three things to do if someone stares at you:
  - Look back and smile
  - Look back, smile and say, *'I'm sorry, do we know one another?'*
  - Ask them not stare
- Two things to say if someone asks you what happened:
  - 'I have a skin condition but I'd rather not talk about it'*
  - 'I've had psoriasis for a few years but it's not contagious'*
- One thing to think if someone appears to turn away:
  - 'It's ok, they didn't mean any harm'*

### **REACHOUT**

- R: reassurance – putting someone at their ease
- E: energy – creating interest in what they are saying
- A: assertiveness – taking the initiative
- C: courage – being strong and taking control
- H: humour – introducing fun or a joke
- O: over there! – distracting away from the skin condition
- U: understanding – being aware that seeing a skin condition can be difficult
- T: tenacity – try again; use a different strategy if the first does not work

# DISABILITY, QUALITY OF LIFE AND ASSESSMENT IN PSYCHODERMATOLOGY

- QOL is an individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns.
- Patients with skin disease are often very clear that their disease has an impact on their lives.
- Managing patients holistically means that clinicians must be able to assess how the patient is feeling and what the impact of their disease is on their QOL.

- There are some very short screening tools; for example the generalized anxiety disorder (GAD) two-question screen.
- If a patient answered affirmatively for either of the following questions, further assessment is important.

### **Question 1**

During the past 4 weeks, have you been bothered by feeling worried, tense or anxious most of the time?

### **Question 2**

Are you frequently tense, irritable and having trouble sleeping?

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## **Box 86.4 Validated tools to measure quality of life (QOL)**

### **Dermatology-specific (but non-disease-specific)**

- Dermatology life quality index (DLQI)
- Skindex 16 and 29

### **Dermatological disease-specific (usually validated for physical and psychosocial disease extent)**

- Cardiff acne disability index
- Simplified psoriasis index
- SCORAD (eczema) score

### **Non-dermatology psychosocial assessments**

- Hospital anxiety and depression score (HADS)
- Generalized anxiety disorder (GAD, GAD-7) score
- Patient health questionnaire 9 (PHQ-9)

### **Measurements of the impact of skin disease on carers and younger patients**

- Children's dermatology life quality index (CDLQI)
- Family dermatology life quality index (FDLQI)

### DERMATOLOGY LIFE QUALITY INDEX

- 01 Over the last week, how itchy, sore, painful or stinging has your skin been?  
بچھلنے پھٹنے میں آپ کی جلد میں کتنی عارض، جلن، درد اور چھین بوتی رہی؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 02 Over the last week, how embarrassed or self conscious have you been because of your skin?  
بچھلنے پھٹنے آپ کو اپنی جلد کی وجہ سے کتنے شرمندہ اور خود کا گروہے؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 03 Over the last week, how much has your skin interfered with you going shopping or looking after your home or garden?  
بچھلنے پھٹنے میں کیا آپ کی جلد کی وجہ سے آپ کو خریداری اور گھر کی دیکھ بھال میں کتنی دشواری پیش آئی؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 04 Over the last week, how much has your skin influenced the clothes you wear?  
بچھلنے پھٹنے میں آپ کی جلد نے آپ کے لباس پر کتنا اثر کیا؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 05 Over the last week, how much has your skin affected any social or leisure activities?  
بچھلنے پھٹنے میں آپ کی جلد کو تفریحی اور سماجی سرگرمیوں کو کتنا متاثر کیا؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 06 Over the last week, how much has your skin made it difficult for you to do any sport?  
بچھلنے پھٹنے میں آپ کی جلد کی وجہ سے آپ کو کھیلنے میں کتنی دشواری ہوئی؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 07 Over the last week, has your skin prevented you from working or studying?  
بچھلنے پھٹنے میں کیا آپ کو اپنی جلد کی وجہ سے پڑھنے اور کام کرنے میں کوئی رکاوٹ پیش آئی؟
- Yes  
No
- ہاں  
نہیں
- If "No", over the last week how much has your skin been a problem at work or studying?  
اگر نہیں تو بچھلنے پھٹنے میں آپ کی جلد پر حائل اور کام میں کتنا مسئلہ بنی؟
- A lot  
little  
Not at all
- بہت  
تھوڑا  
پاکل نہیں
- 08 Over the last week, how much has your skin created problems with your partner or any of your close friends or relatives?  
بچھلنے پھٹنے میں آپ کی جلد کی وجہ سے آپ کو اپنے ساتھی یا قریبی دوستوں اور رشتے داروں کے ساتھ کتنے مسائل پیش آئے؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 09 Over the last week, how much has your skin caused any sexual difficulties?  
بچھلنے پھٹنے میں آپ کو اپنی جلد کی وجہ سے جنسی تعلق میں کوئی مشکل پیش آئی؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں
- 10 Over the last week, how much of a problem has the treatment for your skin been, for example by making your home messy, or by taking up time?  
بچھلنے پھٹنے میں آپ کو اپنے علاج کی وجہ سے کتنی پریشانی رہی، جیسے کہ گھر کا گند اہوتا یا آپ کے وقت ضائع ہونا؟
- Very Much  
A lot  
A little  
Not at all
- بہت زیادہ  
بہت  
تھوڑا  
پاکل نہیں

## **SCORING**

The scoring of each question is as follows:

Very much	scored 3
A lot	scored 2
A little	scored 1
Not at all	scored 0
Not relevant	scored 0
Question 7, 'prevented work or studying'	scored 3

The DLQI is calculated by summing the score of each question resulting in a maximum of 30 and a minimum of 0. The higher the score, the more quality of life is impaired.

## **HOW TO INTERPRET MEANING OF DLQI SCORES**

0 – 1	no effect at all on patient's life
2 – 5	small effect on patient's life
6 – 10	moderate effect on patient's life
11 – 20	very large effect on patient's life
21 – 30	extremely large effect on patient's life

# DELUSIONAL BELIEFS

- **True primary delusion** is a false, unshakeable belief that arises from internal processes which are not amenable to logic and are out of keeping with the person's educational and cultural background.
- Primary delusions can be an
  - a. Isolated phenomenon (a monosymptomatic hypochondriacal psychosis such as delusional infestation) OR
  - b. part of a broader psychosis (e.g. schizophrenia).

- **Secondary delusion**

More commonly occurs with affective disorder and is secondary to the mood (e.g. a nihilistic delusion in severe depression may influence the patient into believing that his/her skin is rotting away).

# DELUSIONAL INFESTATION

- Patient is convinced he is infested with a mite, parasite, bacteria, worm, insect, virus or animate material, even though no infesting organism or material can be found by clinicians.
- Some special forms of DI exist:
  - **DI as a shared delusion (folie à deux, etc.)** Family members, carers and friends may believe that they too are infested, or delusionally share the belief of the individual who is presenting with DI.
  - **DI by proxy**. Patients complain that their child, pet or friend is infested despite all evidence to the contrary.

## AGE

- Occur at any adult age.
- Peak incidence in 50-year-olds.
- Rare in children

## SEX

- Equally distributed

## ASSOCIATED DISEASES

(Table)

**Table 86.1** Diseases associated with or causing delusional infestation (DI).

<b>Primary DI</b>	<b>DI secondary to organic disease</b>	<b>DI secondary to psychiatric disease</b>
No underlying disease	Substance abuse (Figure 86.1) Alcohol Recreational drugs Prescribed medications, e.g. anti-parkinsonian medication such as ropinerole Infections Tuberculosis HIV Endocrine disorders Thyroid disease Cancer Tumours Haematological cancer Chronic or acute liver disease Renal failure Metabolic disease Vitamin B <sub>12</sub> deficiency Autoimmune disorders Systemic lupus erythematosus Multiple sclerosis Brain disorders Cerebrovascular disease Parkinson disease	Schizophrenia Bipolar depression with psychotic symptoms Borderline personality disorder Anxiety disorder

## PATHOPHYSIOLOGY

- Many patients describe an initiating event. This can be a real insect bite, a misinterpretation of a real perception (an illusion) or a true hallucination (sensory experience in the absence of a sensory stimulus)
- Functional MRI in DI patients indicates that there may be abnormalities in the cortical and mid-brain areas associated with the interpretation of perceptions.
- Efficacy of antipsychotic D2-dopamine antagonists may indicate dopaminergic dysfunction in DI.

## PATHOLOGY

- Skin biopsy is best avoided except to exclude other cutaneous differential diagnoses.
- Histology (if it is taken) shows cutaneous excoriations or external trauma at various stages of the healing process.

## PRESENTATION

- Patients present with a belief that they are infested by an organism or animate material.
- Itching, biting, burning or crawling sensations on the skin
- Localized or generalized
- On examination, localized or generalized excoriations, erosions and sometimes ulceration
- These skin changes are produced in an attempt to extricate the organism, usually with the fingernails, nail files, scissors, needles, knives, tweezers and nail clippers and even chemical corrosives.
- Occasionally there are no physical signs at all.



**Figure 86.1** Excoriations in delusions of parasitosis in an amphetamine addict.

- Clinician must check for a genuine infestation.
- Exclude differential diagnoses of DI
- Look for clinical evidence of secondary causes of DI.

## DIFFERENTIAL DIAGNOSIS

- A genuine infestation
- Causes of generalized pruritus
- Immunobullous disease
- Organic disease that leads to secondary DI

## COMPLICATIONS AND CO-MORBIDITIES

- Anxiety, depression or both.
- Risk of suicide in patients with DI.
- Bacterial superinfection of excoriations
- Irritant dermatitis (e.g. from the patient's own use of cleansing agents)  
are common.
- Some patients create severe ulcers and extensive erosions from attempts to eradicate perceived organisms.



**Figure 86.2** Patient with delusional infestation. The marks on the legs are where the patient applied elastic bands to stop the 'worms' from travelling up his leg beneath

## DISEASE COURSE AND PROGNOSIS

- HCPs should treat the skin and the psychological disease concurrently (the 'golden rules')
- Treatment of substance abuse and co-morbid affective disease necessary
- Recurrence of DI symptoms may occur in up to 33% of patients (especially those who have not managed to control recreational drug and alcohol abuse).
- Suicide is always a risk in patients with DI.

## INVESTIGATIONS

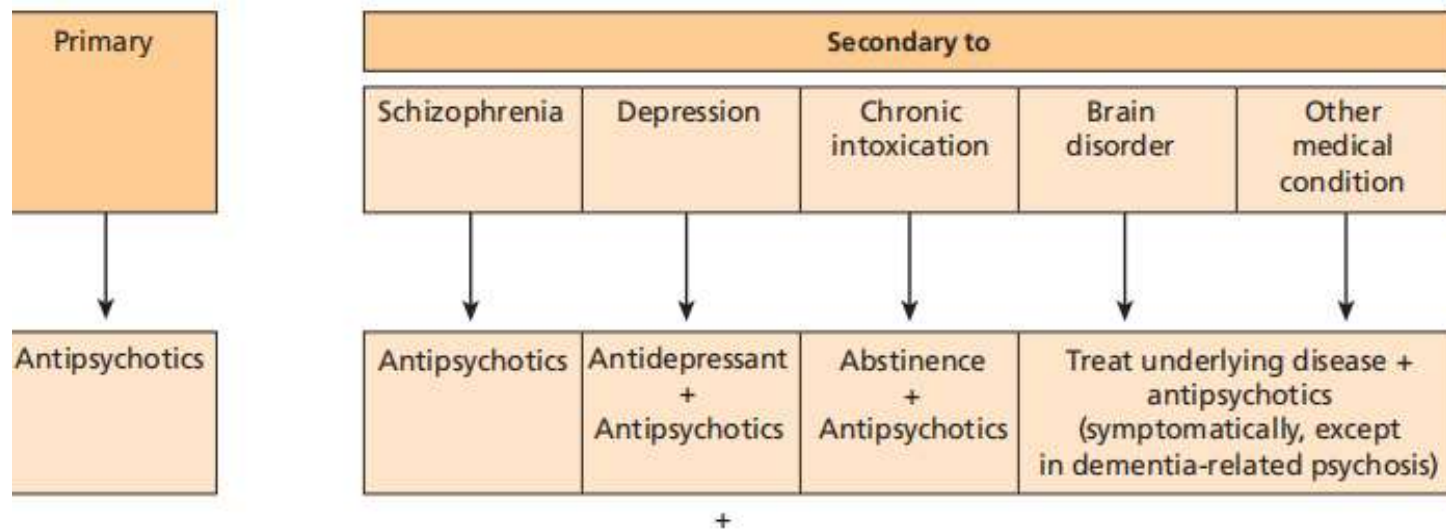
- Patients bring along specimens of the organisms that they believe are infesting them
- This used to be called the 'matchbox sign'
- May bring along audio or computer images of material they have themselves analysed. So now been termed the 'specimen sign'
- Skin debris and specimen material analysed by microscopy.
- Assessment of coexistent affective disease and suicidality
- Assessment of recreational drug and alcohol



(b)

**Figure 86.3** (a) Container brought in by a patient with delusional parasitosis.  
(b) 'Specimen sign' for delusional infestation.

# MANAGEMENT



## Assessments and basic measures:

1. Assess carefully for suicidal ideation and refer to psychiatrists if found.
2. Local treatment of skin lesions and superinfections.
3. Stop pruritogenic medication.
4. Treat pruritus with emollients, antihistamines and occasionally phototherapy.

## Treatment ladder

### First line

- Antipsychotics (choose according to the lifestyle of the patient):
  - Risperidone (0.5–4 mg)
  - Olanzapine (2.5–10 mg)
  - Amisulpride (50–400 mg)
  - Quetiapine (25–100 mg)
  - Aripiprazole (5–15 mg)
- Emollients that contain antiseptics
- Assessment of risk, suicidality and affective disease
- Referral to substance abuse unit if appropriate

### Second line

- Haloperidol
- Pimozide
- Tricyclics (e.g. amitriptyline for itch sensations)
- Antidepressants (usually SSRIs) if there is coexistent affective disease
- Phototherapy
- Antibiotics if a genuine bacterial superinfection is established

### Third line

- Psychotherapy has its advocates but patients may not adhere to this line of treatment

# OLFACTORY DELUSIONS

- Is a primary psychiatric disorder.
- Smell in Olfactory reference syndrome(ORS) is described as being emitted from the patient – intrinsic
- More common in young male adults (male : female 4.5 : 1), and occurs in all ethnic groups.

## ASSOCIATED DISEASES

- Depression.
- Obsessive–compulsive disorders.
- Body dysmorphic disease.
- Dementia.
- Temporal lobe epilepsy

## PATHOPHYSIOLOGY

- Not understood
- ORS may present at the onset of dementia
- May be precipitated by dopaminergic medication for Parkinson disease.
- As part of other psychiatric diseases.

## CLINICAL FEATURES

- Long history of unpleasant smell from a specific part or from all over their body .
- Smell is almost always unpleasant and may be faecal, putrific, sweaty, metallic or acrid.
- Great lengths to cleanse themselves of the smell and
- Some patients have organic brain disease.
- Some patients will also have features of BDD, OCD or both

## DIFFERENTIAL DIAGNOSIS

- A genuine body odour.
- Trimethylaminuria (fish odour syndrome) : is amino acid metabolic syndrome, build up of trimethylamine (TMA) in body fluids
- Temporal lobe epilepsy (olfactory hallucinations common)
- Other organic brain disease: dementia, Parkinson disease, brain tumour

## INVESTIGATIONS

- Urinalysis to exclude trimethylaminuria.
- Clinical examination
- Appropriate neurological investigations

### **Box 86.5 Proposed criteria for diagnosing the olfactory reference syndrome (ORS)**

- A preoccupation with body odour or halitosis that persists despite reassurance that it is not perceived by others
- In someone who recognizes that the preoccupation is unreasonable or excessive
- Which causes significant distress or impairment in function
- And does not occur as secondary to another disorder (e.g. depression, anxiety disorders)
- Or as a result of substances or other organic cause. It can be described as ORS with 'poor insight' where the person only at times recognizes the preoccupation as excessive/unreasonable. However, in these cases, care must be taken not to miss a psychotic disorder

Adapted from Lochner and Stein 2003 [8].

# MANAGEMENT

## Treatment ladder

### First line

- Antidepressants (usually SSRIs) together with appropriate treatment of the skin (this may be asking the patient to wash *less* often)

### Second line

- Atypical antipsychotics in lower doses

### Third line

- Cognitive behavioural therapy (though many believe this to be an important adjunctive first line therapy)

# MORGELLONS SYNDROME

- The phenomenon comprises:
  - Sensations of crawling, stinging and biting under the skin.
  - Sores that do not heal.
  - Fibre-like filaments, granules and crystals that appear on or under the skin lesions
  - Joint and muscle pain and fibromyalgia.
  - Debilitating fatigue.
  - Cognitive dysfunction, poor concentration and memory

## TREATMENT

- Responses to pimozide and risperidone have been recorded.
- Treatment of the skin with topical antiseptics, systemic antibiotics and phototherapy



**Figure 86.5** Sample of the fibres that a patient with Morgellons disease brought to clinic.

# **OBSESSIVE AND COMPULSIVE** **BEHAVIOUR**

It is estimated that OCD is present in up to 25% of dermatology out-patients.

These include

- Body dysmorphic disorder
- Lichen simplex chronicus
- Nodular prurigo
- Skin picking disorder
- Acné excoriée
- Trichotilosis
- Onychotillomania and onychophagia
- Health anxieties

# BODY DYSMORPHIC DISORDER

- Patient is preoccupied with a real or an imagined defect in physical appearance, or if there is a slight physical anomaly, concern is out of proportion to the anomaly
- Female to male ratio 2 : 1
- Often starts in adolescence but may affect any age group.

## PATHOPHYSIOLOGY

- may be related to anxiety disorders and social phobia
- childhood abusive experiences may result in body dissatisfaction, bodily shame, low self-esteem and body image distortion.
- Neurobiological theories relate BDD to acquired brain abnormalities and parietal lobe function

## ASSOCIATED DISEASES

- Chronic skin picking.
- Depression may occur in 60% with a lifetime rate of up to 80%.
- Social phobia
- Substance abuse
- Deliberate self-harm.
- Avoidant personality disorder.
- Anorexia nervosa
- Suicide tendency

### **Box 86.7 Screening questions to assess body dysmorphic disorder**

- How much do you currently think about your skin?
- On an average day, how many hours do you spend thinking about your skin? Please add up all the time that your feature is on your mind and make your best estimate
- Do you feel your skin is ugly or very unattractive?
- How noticeable do you think your skin is?
- Does your skin currently cause you a lot of distress?
- How many times a day do you usually check your skin either in a mirror or by feeling it with your fingers?
- How often do you feel anxious about your skin in social situations? Does it lead to you avoiding social situations?
- Has your skin had an effect on dating or on an existing relationship?
- Has your skin interfered with your ability to work or study, or your role as a homemaker?

Adapted from Veale *et al.* 2012 [12].

## CLINICAL FEATURES

- symptoms according to gender.
- Women may present with a focus on the skin of the face, breasts, nose and stomach
- Men with concerns about hair (usually thinning), nose, ears, genitals and body build.
- Facial symptoms and concerns about hair are common

## Patients will often behave in the following ways:

- Socialize poorly.
- Difficult relationship with mirrors or avoiding mirrors completely
- Pick at their skin.
- Hide their 'defect'.
- Have very persistent and intrusive thoughts about their perceived 'defect'.
- Repeatedly seek help from different HCPs ('doctor shoppers').
- Repeatedly attend for cosmetic or aesthetic surgery.
- Uncommonly familial BDD where a parent imposes a delusional idea upon a child who in turn develops BDD.
- More rarely, the patient believes that their child has a bodily defect – BDD by proxy.

## INVESTIGATIONS

- Mainly a clinical diagnosis, but severity and screening tools do exist.
- Assess for potential suicide risk and refer where necessary.
- Assess for any underlying abuse (physical and mental abuse in a vulnerable adult/child).
- Assess for and investigate underlying psychiatric disease (depression, anxiety or both).
- Acknowledge genuine skin disease (e.g. hair loss or skin pigmentation changes).
- Investigate skin changes appropriately
- Ask about substance abuse.

# MANAGEMENT

## First line

- Treatment of the skin
- Education for patients and their friends and family
- Psychopharmacological treatments (CBT and SSRIs are the treatments of choice) (Higher dosing regimens than those used for depression are usually required)
- Talk therapies (Supportive psychotherapy helpful)

## **Second line**

- Antipsychotics (usually newer atypical such as risperidone, aripiprazole and others)

## **PROGNOSIS**

- Variable, but good, when treated by dedicated BDD teams.

# LICHEN SIMPLEX CHRONICUS AND NODULAR PRURIGO

- Lichen simplex describes characteristic localized skin thickening in response to repeated rubbing and scratching.
- In majority it is the response to anxiety, OCD or an irresistible, persistent itch
- Prurigo nodularis is characterized by the presence of numerous symmetrically distributed hyperkeratotic or eroded nodules due to chronic scratching.
- Presents in two populations:
  - an early-onset atopic group with a mean age of 19 years
  - a later, non-atopic group with a mean age of 48 years
  - older group is predominantly female

## CLINICAL FEATURES

- Regular rubbing and pressure on the skin produces characteristic thickened, coarsely grained papules and nodules with hyperpigmentation
- Common on the nape and sides of the neck, elbows, thighs, knees and ankles.
- Lesions in varying stages of evolution, from early, small, violaceous papules with surface excoriations to chronic areas that present as hyperkeratotic plaques with pigment changes
- Relationship of emotional tension to bouts of scratching
- Patients are usually anxious individuals whose reactions to stress are relieved by habitual behaviour such as rubbing



(a)



(b)



(c)

**Figure 86.6** (a) A patient with nodular prurigo. (b, c) Close up of nodular prurigo.

# MANAGEMENT

## **Treatment ladder**

### **First line**

*Of the skin*

- Emollients
- Topical anti-inflammatories (steroids, calcineurin inhibitors, tar)

*Of the itch*

- Antihistamines
- Tricyclics (e.g. amitriptyline and doxepin)
- Topical antipruritics (menthol, taromacrogols)

*Of the habit (crucial) [7]*

- Habit reversal ([www.atopicskindisease.com](http://www.atopicskindisease.com); last accessed August 2015)
- Other talk therapies

### **Second line**

*Of the skin*

- Phototherapy / photochemotherapy

*Of the itch*

- SSRIs
- Mood stabilizers (pregabalin / gabapentin)

*Of the co-morbidities*

- Other antidepressants, e.g. mirtazapine (sedating)
- Talk therapies

### **Third line**

- Bandages and occlusion
- Systemics (e.g. ciclosporin, azathioprine)
- Intralesional steroids

# SKIN PICKING DISORDER

- Occurs in 2% of dermatology patients, but the majority of these have pathological picking associated with atopic and other cutaneous diseases.
- Two peaks of occurrence:
  - (i) in adolescence and early adult life and
  - (ii) in middle-aged women.
- Females are more commonly affected than males.

## CLINICAL FEATURES

- The lesions differ from other artefactual disorders as those who suffer admit to an urge to pick and gouge at their skin
- Patients usually discuss the picking as a 'response to stress'.
- The average duration of disease before presentation is up to 10 years.
- Patients spend up to 3 hours per day picking
- Lesions may be quite deep, extending into the dermis
- More commonly distributed within reach of the dominant hand.
- Older lesions show pink or red scars, some of which may be hypertrophic.
- Chronic lesions may also show atrophic scars, which merge and are eventually seen as linear, coalescent areas.
- Lesions appear at all stages of development



(a)



## DIFFERENTIAL DIAGNOSIS

- Exclude excoriations caused by generalized pruritus,
- Bullous disorders (such as pemphigus)
- Linear excoriated lesions, which may be the presenting signs of lichen planus or LE.
- Mucinoses that cause scarring
- Acné excoriée

## COMPLICATIONS

- Cellulitis, bacteraemia and septicaemia.
- Scarring.
- Anxiety, depression and guilt.
- Rarely, self-mutilating amputation of a body structure (e.g. breast).
- Suicidal ideation.

# MANAGEMENT

## **Treatment ladder**

### **First line**

#### *Of the skin*

- Appropriate treatment (e.g. antibiotics if there is a clinical infection)
- Antihistamines
- Tricyclics
- Treatment of chronic pruritus

#### *Of the picking habit and co-morbidities*

- Habit reversal
- Other talk therapies
- SSRIs (usually in higher doses)

### **Second line**

#### *Of the skin*

- Phototherapy/photochemotherapy

#### *Of the picking habit*

- Mood stabilizers (pregabalin/gabapentin)
- Other antidepressants, e.g. mirtazapine (sedating)
- Talk therapies

### **Third line**

- Bandages and occlusion
- Intralesional steroids
- Lamotrigine
- Topiramate [10]

# ACNÉ EXCORIÉE

- Particularly in adolescent girls under emotional stress, who pick and squeeze acne lesions.
- Some had no acne at all, so considered a variant of skin picking disorder with the lesions largely confined to the face

## DIFFERENTIAL DIAGNOSIS

- Facial picking disorder
- Trigeminal trophic syndrome
- Dermatitis artefacta

## CLINICAL FEATURES

- Chronic excoriation lesions
- Found predominantly around the hairline, forehead, preauricular cheek and chin areas.
- Extension to the neck and occipital hairline.
- Chronic lesions characteristically show white, atrophic scarring with peripheral hyperpigmentation.
- Lesions are picked as a response to itch or throbbing.
- The lesions are excoriated until emptied’.
- There are usually some acneform lesions, at least when the disease first appears.



(a)



(b)



**Figure 86.9** Acné excoriée.

# MANAGEMENT

## Treatment ladder

### First line

*Of the acne*

- Topical retinoids/antibiotics
- Systemic antibiotics

*Of the habit and co-morbidities*

- Habit reversal [5]
- CBT and other talk therapies [6]
- SSRIs

### Second line

*Of the acne*

- Isotretinoin (usually in ultra-low doses, e.g. 5–10 mg/day; careful monitoring is necessary for all potential side effects but especially affective disease)
- Phototherapy

*Of the habit and co-morbidities*

- Other antidepressants, e.g. mirtazapine (sedating)
- Mood stabilizers (eg pregabalin and gabapentin) [7]
- Talk therapies

### Third line

- Lasers and dermabrasion are best avoided unless they are carried out together with CBT [6]
- Avoid intralesional steroid until the picking habit is under control
- Lamotrigine
- Topiramate
- Hypnosis [8]

# TRICHOTILLOMANIA/TRICHOTILLOSIS

- Recurrent pulling out of one's own hair resulting in hair loss
- Commoner in children and college students
- Childhood between the ages of 5 and 12 years
- Chronic cases who present as adults.
- Preschool children mostly boys
- The adolescent group more likely to be females

## ASSOCIATED DISEASES

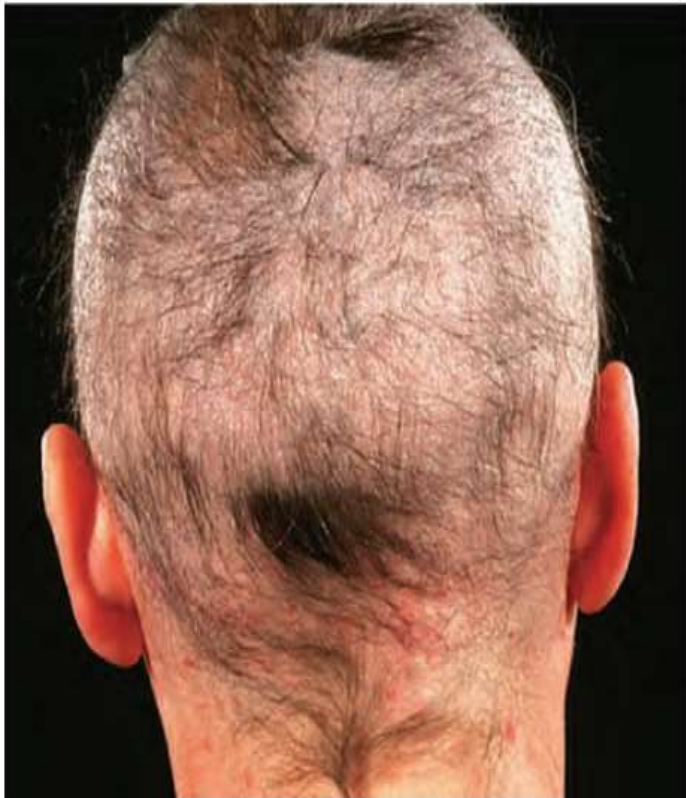
- Aetiology seems to be related to the following :
  - Underlying anxieties.
  - Depression.
  - Underlying BDD.
  - Psychosocial triggers.
  - Family dysfunction (common).
  - Other cutaneous 'habits' such as nail biting and nail pulling.
  - Deliberate self-harm 'cutting', etc.
  - Eating disorders.
  - Rarely substance abuse.
- Familial predisposition is common
- Association with emotional or sexual abuse.

## CLINICAL FEATURES

- Irresistible compulsion that leads to a short-lived sense of relief when hair has been pulled out.
- Relief usually leads rapidly to a sense of guilt and hopelessness.
- Often hidden from the partner/close family and the hair loss is usually covered up.
- Patients feel a sense of control over their body/psychosocial situation that is briefly facilitated by their hair pulling habits.
- The hair pulling activity is usually not as a response to any skin symptoms but is either a conscious, deliberate act or more often a subconscious act
- Hair pulling and plucking is commonest from the scalp.
- Most pull hair from the vertex, but temporal, occipital and frontal hair loss in children may be more obvious on the side of manual dominance.
- Eyelashes, eyebrows, facial and pubic hair may also be primarily affected.

## ON EXAMINATION

- Areas of hair loss together with areas of hair regrowth
- Occasionally frank scarring where follicle has scarred
- The patterns of plucking activity are centrifugal from a single starting point or linear, in wave-like activity
- Chronic folliculitis of the neck, chin, chest, pubic areas or thighs as a result of plucking.
- Children may pluck the hair, or stroke or suck the hair root before chewing and swallowing.
- The hair root alone may be eaten (**trichorhizophagia**)
- In few patients the whole hair is eaten (**trichophagia**)
- Very small percentage develop **gastrointestinal bezoars**



(a)



(b)

11 Adult trichotillomania. (a) Extensive hair loss with a preserved tuft over the occiput. (b) Patient with hairs at different lengths.



**Figure 86.10** Childhood trichotillomania showing eyelash involvement with hair loss and broken-off hairs. This child also had scalp involvement.

## COMPLICATIONS AND CO-MORBIDITIES

- Scarring hair loss.
- Folliculitis.
- Keloid formation.
- Trichobezoar : ball-like aggregations of fibre-like materials in the stomach and small intestine ; symptoms of nausea, indigestion, bloating and pain.
- The Rapunzel syndrome : trichobezoar with a tail that extends at least to the jejunum; sufferers are highly likely to have gastrointestinal obstructive symptoms.



*Completely excised trichobezoar.*



## INVESTIGATIONS

- The diagnosis is usually clinical.
- Scalp biopsy done to distinguish trichotilliosis from scarring alopecia
- Trichoscopy/dermoscopy

# MANAGEMENT

## **Treatment ladder**

### **First line**

#### *Of the habit*

- Habit reversal [7]
- Other CBT [8]
- SSRIs usually in higher doses (especially if there is concomitant anxiety/depression) [9]

#### *Of the hair loss*

- Hair weaves
- Hair extensions
- Treatment of any iron deficiency
- Treatment of keloid

### **Second line**

- Mood stabilizers (e.g. gabapentin and pregabalin) [10]

### **Third line**

- Antipsychotics (under psychodermatological supervision)
- Topiramate
- Phototherapy
- Referral to dissociative state disorder clinics

# ONYCHOTILLOMANIA AND ONYCHOPHAGIA

- The compulsive habits of nail picking (**onychotillomania**) and nail biting (**onychophagia**)
- common in children and adolescents

## AETIOLOGIES

- Stress
- Imitation of family members
- Transference from the thumb sucking habit.

- Damage to cuticles and nails causes paronychia, nail dystrophy and longitudinal nail scarring .
- In chronic cases, association with trichotillois.
- Compulsive biting, tearing or picking with instruments such as scissors, knives or razorblades may lead to permanent destruction.
- Onychotillomania can be a component of self-destructive behaviours in the Tourette and Prader–Willi syndromes.
- Rarely, manifestation of a major depressive disorder that has a suicide risk.
- May respond to CBT.

# HEALTH ANXIETIES

- Irrational fears out of proportion with objective reality, and overwhelmingly distort everyday life
- Predominant cutaneous anxieties (or phobias) can be divided into:
  - Anxieties of contamination, e.g. dirt phobia, germ phobia, wart phobia.
  - Fear of malignancy, e.g. cancer phobia, mole phobia.
  - Others, e.g. blushing, sweating.
  - General health anxieties.

## DIRT, INFECTION AND WART PHOBIAS

- overwhelming fear of contamination or infection of the skin or body.
- Hand washing leading to dermatitis is common
- Hand washing may occur up to 100 times per day and compulsive showering and bathing 10–20 times daily.
- Irritant dermatitis that does not resolve with adequate advice should prompt inquiry, not only about washing compulsions but also checking behaviours

## MOLE AND CANCER PHOBIAS

- an overwhelming fear of developing cancer
- repeatedly demand mole examinations, and sometimes excision
- in response to various stimuli. Eg some previous malignant lesion removed. Or malignancy or death from melanoma in family
- may demand removal of their moles or even attempt self-surgery

# MANAGEMENT

## **Treatment ladder**

### **First line**

- SSRI, often in higher doses, have been shown to be helpful in OCD/health phobias. Mirtazepine is a sedating antidepressant that may be used if patients have sleeping disorders. Citalopram is now used to a maximum of 40 mg; at the moment fluoxetine can be used in doses up to 60 mg
- Talk therapies are essential to address the patient's anxieties and attempt to establish a more rational perspective to their disease
- Appropriate treatment of the skin may be necessary (such as treatment of irritant hand dermatitis in OCD hand washing).
- Mindfulness and relaxation techniques are proving to be very beneficial

### **Second and third line**

- Occasionally antipsychotics may be helpful if the patient presents with delusional disease
- Mood stabilizers (e.g. lamotrigine)
- Treatment of any co-morbid affective disease
- Hypnosis

*Thank You*