DOI: http://dx.doi.org/10.3315/jdcr.2014.1181

Journal of Dermatological Case Reports

PHOTOLETTER TO THE EDITOR

Bullous dermatitis artefacta induced with a hot spoon

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Abstract

A 22-year-old female presented to the dermatology department with a 8-month history of blistering lesions over the left forearm and face. Most of the bullae and erosions were perfectly round and of nearly the same size. In absence of any obvious etiological, precipitating or aggravating factor, a provisional diagnosis of dermatitis artefacta (self-inflicted dermatological lesions) was made. A detailed anamnesis revealed that stress caused by her ex-boyfriend's threats and apprehension of consequences prompted her to create the lesions using a hot spoon. The patients of dermatitis artefacta usually present to dermatologists as their pathology manifests as unexplained and variable cutaneous lesions which may go undiagnosed for a long time. It is important for the dermatologist to have a high index of suspicion to recognise the underlying psychopathology. (*J Dermatol Case Rep*. 2014; 8(3): 81-83)

Key words:

burn, differential diagnosis, factitious disorder, pemphigoid, intraepidermal blister, subepidermal blister

The skin is an organ of immense psychological importance which plays a role in emotional expression as well as in discharge of anxiety. Stress or emotional factors are known to play a secondary role in exacerbating various skin diseases like psoriasis, atopic dermatitis, etc, but in certain psycho-cutaneous diseases like dermatitis artefacta they may play the primary pathogenetic role.[1] These patients usually present to dermatologists with unexplained, variable, cutaneous lesions which are rarely bullous as in our patient and a high index of suspicion is required for diagnosis.

A 22-year-old female presented with a 8-month history of blistering lesions over the left forearm and face. Intact, tense, non-haemorrhagic, 2-3 cm sized, tender bullae were present over apparently normal looking skin on the extensor aspect of left forearm. Examination revealed lesions in different

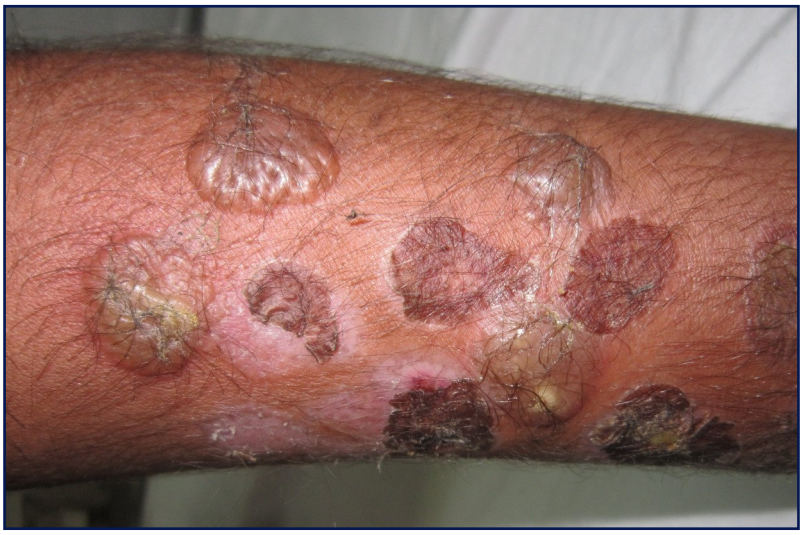

Figure 1

Blistering lesions (left forearm).

stages of evolution with some healing with hypopigmentation (Fig. 1). The initial blisters had appeared spontaneously over cheeks and healed with topical medication leaving post inflammatory hyperpigmentation (Fig. 2). Most of the lesions, bulla, erosions or patches of hyperpigmentation were perfectly round and nearly of same size. Nikolsky sign and bulla spread sign was negative. The general health of the patient was unaffected. There was no history of loss of sensation or similar lesions in family members, no precipitating or aggravating factors such as trauma, photosensitivity or topical applications. In absence of any obvious etiological, precipitating or aggravating factor, a provisional diagnosis of dermatitis artefacta was made.

The complete blood count, serum biochemistry, urine and stool examination were normal. Histopathological examination revealed a variable subcorneal, intraepidermal and dermo-epidermal split containing neutrophils without acantholysis. Upper dermis showed mild perivascular lymphocytic cell infiltrates.

Both the patient and her parents were reluctant for psychiatric consultation but agreed to individual conversations with the dermatologist. The patient was second in birth order (one elder brother and two younger sisters) with no history of sibling rivalry or conflict. She was engaged to be married but the wedding had been postponed because of the present illness.

The parents revealed that she had not shared any concerns with them though she seemed anxious at times.

The patient revealed that before her engagement she had been in a serious relationship with another man. She had ended the relationship a year age because of her boyfriend's anger management problem. Subsequently she got happily engaged to a man chosen by her parents. Her ex-boyfriend started threatening to reveal their past relationship to her fiancé and his parents in order to stop her marriage. She became extremely apprehensive and thought of postponing her wedding on some pretext till she could convince him not to do so. This resulted in the idea of creating some visible disease which could be helpful in postponing the wedding and may also make her ex-boyfriend sympathetic enough to abandon his plans.

She revealed that under the excuse of making tea she would go into the kitchen and cause a superficial burn with a hot spoon on her skin. She would then complain of itching, redness and blistering over the site. She continued to create new lesions as the previous ones healed.

She was convinced about the need for psychiatric evaluation and counselling. Disclosure of the threats to her parents led to disappearance of her fear of the consequences. Reassurance and parental support led to resolution of psychological problem. She stopped creating new lesions and is free of disease at 6 months of follow up.

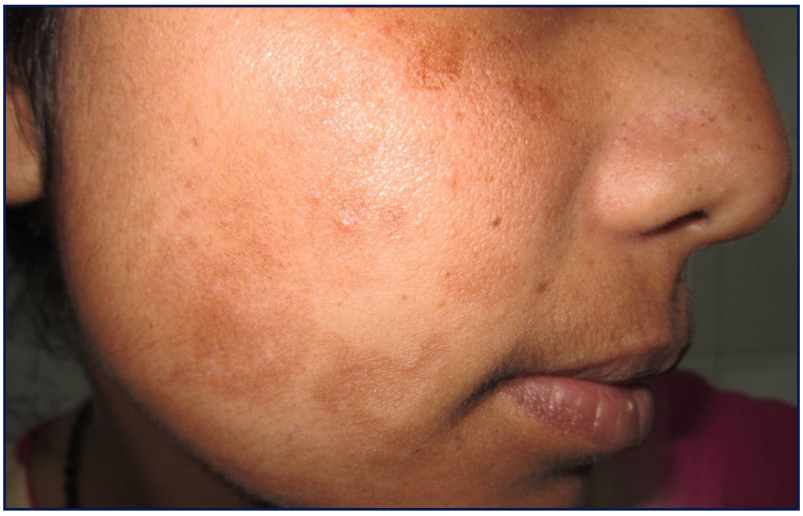

Figure 2

Post-inflammatory hyperpigmentation (right cheek).

Discussion

Factitious skin disorders include dermatitis artefacta (DA) along with dermatitis simulata, dermatological pathomimicry, and dermatitis passivata. DA is a self inflicted dermatoses usually caused by the fully aware patient for secondary psychological gain. Adolescents and young adults are most commonly affected although no age is exempt. There is female preponderance (female:male ratio range from 20:1 to 3:1).[2,3] The usual sociodemographic profile of the patient is a single person with low educational level and few or no job qualifications or skills.[3]

The clinical manifestations reveal a use of creative methods involving diverse but easily available household items. The usual lesions are mechanical injuries by pressure, friction, occlusion, excoriations, biting, cutting, or self inflicted impairment of healing over the easily accessible parts of the body depending on the substance and method used. Bullous lesions are rare and may be induced by various techniques like heat, chemicals, electric current or even deodorants.[4,5] The patients usually present to a dermatologist with fully formed lesions and deny any knowledge about its causation.

The patients are usually immature and neurotic with a borderline personality disorder who are unable to cope with an adverse situation. They use physical symptoms to communicate emotions and psychological conflicts. The visible skin lesions satisfy their unconscious psychological motive to draw attention towards themselves and to be taken care of. These patients usually present to a dermatologist rather than a psychiatrist because of the stigma attached to psychological disorders. Both the patient and family are unwilling to acknowledge the psychological component of this disease despite all clues pointing to it. The recognition of the underlying psychopathology by the dermatologist and establishing a rapport with the patient is imperative for the treatment.

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