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An Atypical Rash: Factitious Dermatitis

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1. Abstract

1.1. Introduction: Factitious Dermatitis (FD) is defined as the lesions that the patient creates on their own to fulfill a psychological need that they are usually unaware off.

1.2. Case: An 11-year-old male patient was presented with rashes which starts with a burning sensation and heals by scabbing and located on his legs, anterior trunk and neck, appeared within the last 3 months. Abrasion and excoriation marks with irregular edges, each 0.3-0.5 cm in diameter, were detected. It was learned that new rashes appeared especially nights before school days, and that he had problems with his teacher and friends at school. He diagnosed with FD and his treatment arranged by the child psychiatry department. On his follow-up one month after initiation of the treatment, it was observed that he had no new lesions.

1.3. Discussion: The prevalence of FD is seen more frequently in females and highest in adolescence and early adulthood. Lesions are mostly localized on the face and arms. In most cases, psychosocial stressors can often be identified as triggers for this disease. Treatment can be difficult and management of the disease should be a multidisciplinary team approach of pediatricians, dermatologists and mental health professionals. Pediatricians should be aware of FD, given that pediatric patients with a rash often refer primarily to their pediatrician.

2. Introduction

Factitious Dermatitis (FD), also known as dermatitis artefecta, is the dermatological reflection of factitious disorders listed in DSM-V classification, which is considered a psychiatric disease. It is defined as the lesions that the patient creates on his own to fulfill a psychological need that he is usually unaware of, and patients often deny that they caused the lesions themselves [1]. These lesions are often suspicious, have interesting morphology, sharply demarcated demarcation lines, are less responsive to treatments, and persist for a long time. It usually occurs overnight in an area within the individual's reach and in a previously healthy skin area [2]. In this article, an 11-year-old male patient who was diagnosed with factitious dermatitis with a multidisciplinary approach is presented.

3. Case

An 11-year-old male patient was admitted to the pediatric outpatient clinic due to rashes on his legs, anterior trunk and neck occured within the last 3 months. It was learned that he had many hospital admissions with similar complaints and that he used topical corticosteroid and topical antibiotic ointments, but to no avail. When the history of the lesions was questioned, it was learned that the rash usually appeared in the evening hours, a burning sensation occurred during the first appearance of the rash, and it healed by scabbing. There were no features in patient's history and family history. On physical examination, abrasion and excoriation marks with irregular edges, each 0.3-0.5 cm in diameter, were detected on the anterior trunk, legs and arms (Figure 1). It was noted that the rashes did not spread to the back and face area. Since the morphology of the lesions is not similar to any disease and the affected areas are accessible and not easily noticeable, it was thought that they may have been caused by the patient himself. When the patient was asked about it, he declared that he did not do it himself. When the patient's history was deepened with the preliminary diagnosis of FD, it was learned that new rashes appeared especially on the nigts before the school days and that he had problems with his teacher and friends at school. The diagnosis of the patient was

confirmed by other departments (dermatology and child psychiatry) and his treatment was arranged by the child psychiatry department. When the patient came to the follow-up one month after the start of the treatment, it was observed that he had no new lesions.

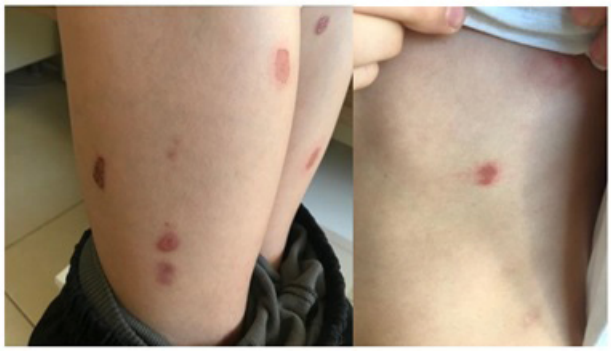

Figure 1: The patient's lesions under the lower extremity and chest

4. Discussion

The prevalence of FD is highest in adolescence and early adulthood, and it is very rare in young children [3]. FD is seen approximately 8 times more frequently in females than males. Lesions are mostly localized on the face and arms. Superficial excoriations triggered in different ways are the most common lesions, followed by hyperpigmented patches, dermatitis, necrosis, ulcerations, crusts, and purpuric and bullous lesions [1]. The pattern of the lesions varies according to the mechanism of injury, and patients cannot fully explain how the lesions occur [5]. Our case differs from the cases in the literature in terms of age, gender and distribution region of the lesions.

The differential diagnosis of FD covers many diseases; contact dermatitis, pyoderma gangrenosum, drug eruption, vasculitis, ecthyma, panculitis, physical/sexual abuse are among these diseases [5]. In a study on this subject, it was stated that common stress factors among children are upcoming exams, disagreements at home, being bullied by children at school, and loss of family and loved ones. In most cases, psychosocial stressors can generally be defined as triggers, and it is essential for the clinician to reveal why the patient presents with FD [2]. The diagnosis is a diagnosis of exclusion and is often difficult to confirm as patients rarely acknowledge their role in the formation of their lesions. Treatment can be difficult and the management of the disease should be in the form of a multidisciplinary team approach consisting of pediatricians, dermatologists and mental health professionals [2, 3, 5]. Seeing it by a pediatrician, dermatologist or psychiatrist alone is unlikely to resolve FD [2]. Pediatricians should be aware of FD, given that pediatric patients with a rash often refer primarily to their pediatrician.

References

1. Finore ED, Andreoli E, Alfani S, Palermi G, Pedicelli C, Paradisi M. Dermatitis artefacta in a child. Pediatric Dermatology. 2007; 24(5): E51-E6.
2. Mohandas P, Bewley A, Taylor R. Dermatitis artefacta and artefactual skin disease: the need for a psychodermatology multidisciplinary team to treat a difficult condition. British Journal of Dermatology. 2013; 169(3): 600-6.
3. Chiriac A, Brzezinski P, Pinteala T, Chiriac AE, Foia L. Common psychocutaneous disorders in children. Neuropsychiatric Disease and Treatment. 2015; 11: 333.
4. Uçmak D, Harman M, Akkurt ZM. Dermatitis artefacta: a retrospective analysis. Cutan Ocul Toxicol. 2014; 33(1): 22-7.
5. Mohandas P, Bewley A, Taylor R. Dermatitis artefacta and artefactual skin disease: the need for a psychodermatology multidisciplinary team to treat a difficult condition. Br J Dermatol. 2013; 169(3): 600-6.