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Dermatitis Artefacta Mimicking Facial Decubitus Ulcer

CASE REPORT
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ABSTRACT

Dermatitis artefacta is a psychocutaneous disorder defined by the intentional self-damage of a patient's integumentary system. Taking into consideration the psychiatric background of the disease as well as the variability of its clinical manifestations, the establishment of diagnosis is challenging. An interesting case of a 65-year-old woman who presented to the emergency department with an inflamed bedsore-type lesion in the lower third of the face is reported. The confession of the pathogenetic mechanism of the ulcer in association with the patient's psychiatric medical record led to the diagnosis. Through this case report, the interprofessional therapeutic protocol built of rigorous surgical debridement, antibiotic administration, and psychiatric support have been delineated.

Keywords: Dermatitis artefacta, pressure ulcer, surgical debridement

Introduction

Dermatitis artefacta is a psychocutaneous disorder characterized by the presence of self-inflicted lesions in the integumentary system.[1] Etiology is mainly attributed to psychiatric morbidities, principally comprising depression and anxiety. There is a wide range of clinical presentations, mimicking several diseases.[2] Erosions, crusts, excoriations, and ulcerations are classified among the miscellaneous cutaneous lesions.[2] The face constitutes the most frequently involved body part, while the female-to-male ratio fluctuates between 20 : 1 and 3 : 1.[3]

Case Presentation

A 65-year-old Caucasian woman, with a history of bipolar disorder and denying other concomitant diseases, presented to the emergency department due to an extensively inflamed scar on the left side of the mentum, resembling a stage 3 pressure ulcer. The patient admitted that the formation and gradual evolution of the ulcer had been starting 3 months ago, because of deliberate and repetitive exertion of manual friction and fingernail-induced shear force injury, for the purpose of satisfying a psychological need that is not consciously understood by the patient. On inspection, the ulcer's shape is ovoid with full thickness skin loss extending to the subcutaneous tissue but excluding the fascia of the mentalis and depressor labii inferioris muscles beneath it. The undermining of tissue under the edges of the intact skin enlarges the ulcer area at the base in comparison to that of the skin surface. There is abundant wound exudate, while the skin of the surrounding area is erythematous bearing another minor stage 2 ulcer, distinguished by partial thickness skin loss with exposed dermis (Figure 1). The computed tomography scan revealed soft tissue loss of thickness and edema anteriorly to the mental protuberance, accompanied by air accumulation and scanty fluid collection. The patient was admitted to the Otolaryngology Department, undergoing meticulous surgical debridement of devitalized tissue under sedation twice, with a 7-day interval (Figures 2 and 3). The therapeutic plan is composed of IV antibiotic administration and copious wound irrigations with hypertonic saline solutions succeeded by packing with calcium alginate dressings to promote secondary wound healing. *S. aureus* was identified

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Figure 1. Ulcer of the mentum upon presentation in the emergency department.

in the microbiological culture of exudative effusion, which was sufficiently covered by the selected empiric antibiotic course. The biopsy result confirmed the necrotic inflammation in conjunction with the presence of granulomatous tissue, eliminating the risk of malignancy. Concurrently, the patient was supervised closely by psychiatrists, being under treatment with diazepines and selective serotonin reuptake inhibitors. After 1 month of thorough wound care, there was complete tissue regeneration along with a satisfactory cosmetic outcome (Figure 4). Informed consent was obtained from the patient who agreed to take part in the study.

Discussion

Dermatitis artefacta is a psychocutaneous disorder of the integumentary system that may affect any part of the human body, imitating a considerable amount of clinical entities.[1] Vivid imagination is required for the description of the various pathogenetic mechanisms dependent on the patient's social and educational status. Taking into account that the diagnosis of dermatitis artefacta is one of exclusion, the patient contributed to the maximum by admitting her role in the creation of the lesions, underscoring the significance of the thorough medical history. Misdiagnosis remains a possibility in the context of the psychiatric background. This is primarily attributed to the overlapping clinical features observed in the group of factitious dermatoses, rendering the proper interdisciplinary collaboration crucial in the understanding of the involved pathogenesis and psychodynamics.[3,4]

MAIN POINTS

- *Dermatitis artefacta is classified among the self-induced dermatoses.*
- *The therapeutic approach is composed of IV antibiotic administration, surgical debridement, and usage of psychotropics.*
- *Establishing the diagnosis of dermatitis artefacta is perplexing, simultaneously demanding a high clinical suspicion.*
- *The prognosis is poor owing to the relapsing-remitting nature of the underlying psychiatric disorder.*

Figure 2. Ulcer after the 1st surgical debridement.

Bearing in mind the National Pressure Injury Advisory Panel's definition, the existing artefactual facial lesions simulate localized damage to the skin and underlying soft tissue over a bony prominence such as the mental protuberance, as a result of intense and prolonged exertion of manual friction and fingernail-induced shear force.[5] Consequently, the induction of necrosis is catalyzed by the sustained pressure upon the underlying capillary network, ultimately leading to local tissue hypoxia. Among the pathogenetic mechanisms,

Figure 3. Ulcer after the 2nd surgical debridement.

Figure 4. Final cosmetic outcome of the ulcers.

reperfusion injury should be added owing to its inflammatory role in the generation of oxidative stress.[5]

The medical team reached a unanimous decision that the patient must be hospitalized aiming at her optimal medical care and psychological support. In humans with normal sensation and mental status, incessant pressure elicits a feedback response which is impaired in a bipolar disorder relapse.[5,6] Off-loading of the causative factors reverses the pathogenetic process, constituting an indispensable element of the therapeutic approach.[7,8] The nursing and medical staff must be aware that the exerted pressure shall be restrained in the implicated body part, an action of utmost importance in both rehabilitation and prevention.

The first step in wound repair and regeneration encompasses a generous amount of hypertonic saline irrigations aiming at ulcers' purification, while avoiding cytotoxic agents like hydrogen peroxide and povidone-iodine solutions.[7] Surgical debridement obliterates necrotic tissue and slough and eradicates bacterial biofilm, enabling the healing process. Then comes the secondary wound healing through the local application of either paraffin gauze or calcium alginate dressings, especially in case of abundant wound exudate. The underlying target is to balance exudate and moisture in the right proportion, impeding maceration, irritation, and breakdown of the adjacent viable tissue.[7]

Furthermore, the Wound Healing Society recommends the incorporation of additive therapeutic agents such as platelet-derived growth factor or platelet-rich plasma for pressure ulcers that fail to respond to traditional medical treatment.[7] Vacuum-assisted closure/negative pressure wound therapy remains a beneficial alternative in the management of end-stage pressure ulcers. In such cases, surgical management with a skin flap may be contemplated, particularly when more conservative therapeutic options are proven insufficient. Over time, the healing of facial pressure ulcers may end up with unsightly cicatrix formation, simply accompanied by hyperpigmentation, although more demanding cases comprise hypertrophic and keloid scars requiring additional interventional procedures.[9]

Routine performance of swab cultures is contraindicated unless the ulcer wound stands a good chance of infection.[7] Once signs of infection are perceptible, oral antibiotics should be introduced in the therapeutic regimen.[10] There is a remarkable predisposition of high-degree ulcers to undergo complications such as osteomyelitis, rendering magnetic resonance imaging and bone biopsy candidates as diagnostic modalities in the workup. In such circumstances, intravenous antibiotic administration and hospitalization are mandatory.[7]

The diagnosis of dermatitis artefacta is challenging and should be part of the differential diagnosis of every chronic and puzzling dermatosis, demanding a high clinical suspicion. Failure of diagnosis or undertreatment may precipitate serious self-mutilation and poor aesthetics with disfiguring scars, not to mention the infectious and inflammatory complications that can be life threatening at times. The prognosis is poor on account of the patient's proneness to "wax and wane" depending on the incidents in life, thus justifying the need for a constant and regular follow-up with an interprofessional team.[1,2] Taking everything into consideration, the establishment of trust, honesty, and empathy in the doctor-patient relationship is a prerequisite to accomplish a positive response to the therapeutic regimen.

Data Availability Statement: *The data that support the findings of this study are available on request from the corresponding author.*

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