IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 23, Issue 1 Ser.6 (January. 2024), PP 46-50
www.iosrjournals.org

Cutaneous Pathomimias In Children: A Diagnostic Challenge

Sonia Sehim[1], Imene Mahiou[2,]
[1](Department Of Medicine, Psychiatric Specialty / University Benyoucef Benkhedda Of Algiers 1, Algeria)
[2](Department Of Medicine, Dermatology Specialty / University Benyoucef Benkhedda Of Algiers 1, Algeria)

Abstract:
Cutaneous pathomimias, or dermopathomimias, are defined as factitious disorders entirely induced by the subject in a clear state of consciousness, affecting the skin or mucous membranes and/or appendages, with varied clinical presentations. The diagnosis is considered in the presence of lesions with sharp, often geographical borders, located in easily accessible areas and a specific psychological context. They pose one of the most complex challenges for dermatologists and psychiatrists. We report a case of an 11-year-old girl presenting with cutaneous pathomimia in the form of ecchymotic plaques topped with erosive-crusty and necrotic bullous lesions on the face and neck. Skin biopsy revealed no abnormalities, and immunofluorescence was negative. Psychiatric examination revealed a specific psychological profile for the young girl. Based on the anamnestic and clinical data, negative paraclinical findings, psychological examination results, and healing of the lesions under occlusive dressings alone, the diagnosis of cutaneous pathomimia was established after ruling out differential diagnoses, including known dermatoses and other psychiatric differentials. Management requires early multidisciplinary involvement and combines medical and psychological interventions. Clinicians should be aware of this stereotyped clinical aspect of pathomimia.

KeyWord*: Cutaneous pathomimia – factitious disorder – induced lesions – psychotherapy.*

Date of Submission: 10-01-2024 Date of Acceptance: 20-01-2024

I. Introduction

Cutaneous Pathomimias represent a distinct form of factitious disorders (formerly Munchausen syndromes), entirely induced by the subject in a clear state of consciousness on their own body to fulfill a psychological need of which they are unaware [1-3]. The chronic course of these conditions can be marked by severe complications.

Despite their classification within the realm of psychiatric disorders, Pathomimesis is often encountered by somatic practitioners. Psychiatrists frequently become involved only at a later stage in patient care [4]. It is noteworthy that dermatological pathomimias are not uncommon in children, and their frequency is likely underestimated, given the often-delayed diagnosis [4-5]. These occurrences are more prevalent in prepubescent girls who psychologically need to assume the role of a patient without apparent benefits [6-7].

Dermopathomias are the most frequent, as the skin is a visible and easily accessible organ, and their clinical presentations vary widely depending on the methods employed by these children. Importantly, there is no specific rational motive explaining such pathological behavior, and patients often do not recognize their responsibility, distinguishing this behavior from simulation and lesions caused by compulsive behavior [8-9]. Literature case studies have reported academic difficulties or familial crises in children suffering from dermatological factitious disorders [1].

This manifestation is a potentially serious psychopathological expression, often challenging to label and manage, making it one of the most complex diagnostic and therapeutic issues for dermatologists and psychiatrists. We present a case of pathomimia in an 11-year-old girl, manifested through cutaneous lesions on the face and neck.

II. Patient And Observation

The case involves an 11-year-old girl, an only child, attending school. In her medical history, there is a history of school phobia, enuresis, and a generalized blistering rash at the age of 3, which was treated and resolved. The mother was under psychiatric care for anxiety and depressive disorders following her divorce, struggling to fulfil her responsibilities towards her daughter.

Dermatological Examination

The physical examination revealed ecchymotic plaques topped with vesiculo-bullae on the neck, associated with bullous, erosive-crusty, and necrotic lesions on the face. These lesions were well defined, with sharp and geographical borders on healthy skin, evolving for the past 45 days. The bullae were intensely pruritic at the hairline, with no history of insect bites or application of topicals. Secondary extension to the face and neck was observed (Figure 1).

There was no response to antibiotics, antihistamines, or dermocorticoids. In addition to the previously described lesions, skin atrophy on the forehead and anetoderma on the arms were noted. The rest of the examination was unremarkable.

The clinical presentation occurred in the context of afebrile conditions, and the general condition was well-preserved. Due to the severity of the lesions, emergency hospitalization was warranted. Despite efforts, satisfactory explanations regarding the origin of the lesions could not be obtained. The girl was referred for psychiatric consultation during her hospital stay to establish a correct diagnosis.

Psychiatric Examination

The interview coupled with the psychiatric examination revealed unfavorable living conditions and a family in crisis, the parents were divorced when their daughter was 3 years old. She currently resides with her mother and grandparents. The mother has intentions of starting a new life, causing the child to experience feelings of anxiety, separation, and abandonment. Childhood traumas, including psychological abuse and neglect from the mother and grandparents, were also identified. There was a history of school phobia and a similar episode of generalized skin lesions following stressful life events.

In terms of presentation, only the girl's face and neck, covered with bandages, were visible. Establishing contact was easy but laborious. The mood tended towards anxiety, but there were no signs of depression. The young patient was very concerned about separation from her mother. There were no delusions or hallucinations. However, she was highly reluctant or sometimes mute when discussing the dermatological issue. Upon questioning her again about her skin lesions, she timidly explained that it was due to itching, leading her to scratch until bleeding, insisting that it did not hurt, speaking softly while staring at the floor without admitting that she was the perpetrator.

At this stage of the interview, it was futile to seek the "confession" from the girl and details about the methods used to induce these skin lesions. With each response, the girl avoided eye contact with the interviewer and sometimes evaded questions. It was also revealed that she experienced moments of solitude with feelings of abandonment, expressing sadly, "my father abandoned me, now it's my mother's turn." Indeed, the girl felt rejected and abandoned by all the significant people in her life. Instinctual functions were disturbed, notably in the form of eating disorders, leaning towards anorexia or bulimia.

Several elements stand out regarding the psychological profile of the girl:

- Firstly, she began self-inflicting skin injuries at the age of eight as a response to cumulative stress events.
- Intellectually, she is intelligent with a good academic level, but she also experiences episodes of eating disorders such as anorexia and bulimia.
- Lastly, she exhibits a highly anxious personality with emotional sensitivity above normal, likely stemming from separation anxiety and moderately intense emotional deficiencies.

Para-clinical Examination

The biological assessment did not reveal any inflammatory syndrome or leukocytosis. Bacteriological and mycological samples were sterile. The antinuclear factor (ANF) and antiphospholipid antibody syndrome (APS) were negative. The anatomo-pathological study of the skin biopsy showed a skin surface devoid of hemorrhagic epidermis. Where the epidermis was visible, there was discreet acanthosis and spongiosis highlighted by focal moderately para-keratotic hyperplasia (lesions lacking specificity).

The application of direct immunofluorescence (DIF) to skin biopsies to investigate autoimmune bullous dermatoses was negative.

In summary, following various examinations, including dermatological, psychological, paraclinical, and histological (biopsy), we conclude the diagnosis of dermopathomimia in a girl with a very fragile psychological profile, seeking attention and affection. This disorder is likely adopted as a means to discharge aggressive impulses directed towards the mother and turned inward.

Evolution of Dermatological Symptoms

The approach to management was multidisciplinary, involving both the dermatologist and the psychiatrist. The dermatologist oversaw the treatment of the skin lesions, while psychological care was primarily based on psychotherapy. Initially, supportive psychotherapy provided the girl with a space to express her fears and feelings, helping her understand the relationship between psyche and somatic aspects, with the goal of alleviating all

negative impulses directed inward. Subsequently, family therapy played a pivotal role in the intervention. Collaborative work with the mother and grandparents helped address negative family emotions, along with efforts to modify behaviors towards the girl to prevent relapses.

By the fifteenth day, there was a noticeable improvement with the initiation of healing under local treatment and occlusive dressings alone, coupled with the absence of new lesions, further confirming the diagnosis of dermopathomimia (Figure 2 and 3). The girl was reviewed at three months (90 days) post-hospital discharge, revealing no recurrence but the persistence of atrophic scars on the face and keloids on the neck (Figure 4). Currently, the girl continues to be monitored within a multidisciplinary framework involving the dermatologist and child psychiatrist.

III. Discussion

This is a clinical presentation of localized factitious dermatological disorder on the face and neck with bullous lesions, initially posing a diagnostic and therapeutic challenge, accompanied by a history of medical nomadism. In the case of this young girl, the diagnosis of dermatopathomimesis was based on a cluster of clinical evidence and the absence of specific findings in paraclinical data, ruling out a known dermatological disease.

Additionally, the diagnosis relied on significant elements from the medical history, revealing a dysfunctional family environment, separation anxiety, feelings of abandonment, and childhood traumas within the family. Factitious disorder is thus akin to pathomimesis, as described in 1908 by Dieulafay: "pathomimes derive no profit, no benefit from their acts, but they experience an intimate joy in making themselves interesting and eliciting sympathy." This disorder is considered a somatic expression of significant psychological distress [10-11].

In other words, it represents the cutaneous somatic expression of an often-severe psychiatric disorder. Currently, factitious disorders are recognized in international classifications of mental illnesses [12-13].

The World Health Organization's International Classification of Diseases (ICD-10) individualizes this disorder among significant personality and behavior disorders in adults [12].

The Diagnostic and Statistical Manual of Mental Disorders in its 5th edition (DSM-5) [13] includes factitious disorders in the category titled "Somatic Symptom and Related Disorders," emphasizing their cognitive, behavioral, and especially affective aspects. Factitious disorders adhere to three criteria: intentional production of physical or psychological signs or symptoms, motivation to play the role of a sick person, and the absence of external reasons for such behavior [3].

Dermatopathomimesis, or cutaneous factitious disorder, is thus considered a factitious illness involving the intentional production of physical signs or symptoms on the skin and/or appendages [1].

Clinically, the lesions exhibit specific characteristics, often well-defined, painless, either singular or multiple. They typically appear on exposed areas (face, neck, hands, forearms) and may resemble blisters, abscesses, bruises, or eczematous lesions [14-15]. Excoriations, ulcerations, and pruritic ecchymotic lesions are the most frequently observed according to literature data [16-17]. In our young patient, the topography and semiotics of the lesions were indicative of the diagnosis, classically, they presented as pruritic, bullous, erosive-crusty, necrotic lesions with an ecchymotic base.

They emerge abruptly on healthy skin, are well-defined, and have geographical contours. Indeed, in this factitious pathology, the bullous nature of the lesions has rarely been reported in the literature [15-18]. However, remaining a diagnosis of elimination, other dermatoses have been mentioned, namely, epidermolysis bullosa acquisita type of pemphigoid of Brunsting Perry, which is defined clinically by pruritic and recurrent vesiculo-bubbles evolving towards atrophic scars located on the face and neck. Or, veseculo-bullous lupus erythematosus, which can be the first manifestation of systemic lupus erythematosus, due to its location on photo-exposed areas of the body. On the other hand, dermatological manifestations of an anti-phospholipid antibody syndrome, in the presence of anetoderma, erosive-necrotic and purpuric lesions. It's important to note that hese diagnoses were ruled out due to the negativity of the biological, immunological and IFD assessments as well as the non-specificity of the biopsy.

Subsequently, the lack of admission on the part of the young girl allowed us to exclude other self-induced dermatoses falling within the realm of psychiatric disorders, including simulation, self-mutilation, and neurotic excoriations, which are often encountered in children with severe behavioral issues and significant emotional deficiencies. Child factitious disorders most commonly arise in a family environment-undergoing crisis (separation, divorce) and/or in a situation of academic failure, often serving as a genuine cry for help [19]. This is evident in the case of our patient.

The management of such a patient requires early multidisciplinary involvement [20]. Collaboration among dermatologists, psychiatrists, and psychologists is essential to develop a shared therapeutic plan [16, 20]. In this multidisciplinary approach, there appears to be a sequence in the interventions of each professional, with somatic care preceding psychiatric care once adolescents and their families become aware of the existence of psychological suffering and its impact on the body. Psychological care involves rendering the lesions inaccessible through

bandaging and dressings in our patient, leading to rapid healing and the absence of new lesions, supporting our diagnostic hypothesis.

In these cases, the prognosis is good, and improvement occurs once the underlying conflict is addressed, providing emotional support to the child. Our patient lived in a conflicted family environment, and the announcement of her mother's remarriage caused an emotional shock, expressing her distress through these conspicuous lesions to seek attention and emotional solace. In other words, skin excoriations can be a way to cope with intense emotional pain by shifting it to another form of pain. In conclusion, the psychoanalytic meaning of this disorder is as if the girl consoles herself, with her skin being, in a sense, the transitional object.

It is noteworthy that case studies on factitious disorders in children show a better prognosis than in adults [6, 14]. As for the approach, the main therapeutic goal is psychological, and it is crucial to cease extensive investigations and therapeutic escalation. Confronting the child directly or seeking admission at any cost should be avoided to prevent somatic and psychological decompensation. Generally, psychotherapeutic approaches to disclosing the diagnosis of factitious disorders to patients involve a non-aggressive, non-punitive, and non-confrontational approach.

Alternatively, some experts recommend psychological treatment without requiring patients to admit their role in their illness. Regarding the contribution of cognitive-behavioral therapy, it is currently being identified and initiated in children. Cognitive-behavioral therapy allows the correction of certain erroneous thoughts [21].

Conflict of Interest

The authors declare no conflicts of interest.

Authors' Contributions

All authors contributed to the completion of this work and have read and approved the final version of the manuscript.

Figures

Figure n° 1: Ulcero-crustaceous and atrophic lesions on the face and neck
Figure n° 2: Inflammatory scar plaque on the neck
Figure n° 3: Keloid scar on the neck
Figure n° 4: Occlusive dressing and directed healing

Figure n° 1

Figure n° 2

Figure n° 3

Figure n° 4

IV. Conclusion

Cutaneous factitious disorders in children result from an intrapsychic conflict that extends beyond the patients themselves. The diagnosis is often delayed, and their management proves challenging. Healthcare professionals, especially dermatologists, pediatricians, and child psychiatrists, should be adept at distinguishing dermatopathomimias based on both somatic and psychological considerations. Establishing a trusting relationship between the therapist and the child is crucial for ensuring a strong therapeutic alliance. It is essential to prevent and treat lesions by using appropriate dressings and care while motivating the patient.

References

[1]. Gieler U, Consolf Sg, Tomas-Aragones L, Linder Dm. Self-Inflicted Lesions In Dermatology: Terminology And Classification, A Position Paper From The European So Ciety For Dermatology And Psychiatry. Acta Derm Venereol. 2013; 93 (1): 4-12.
[2]. Wong Jw, Nguyen Tv, Koo Jy. Primary Psychiatric Conditions: Dermatitis Artefacta, Trichotillomania And Neurotic Excoriations. Indian J Dermatol. 2013; 58 (1): 44-8.
[3]. Misery L. Skin Pathomimias. Medico-Psychological Annal, Psychiatric Journal. Volume 168, Issue 4, May 2010, Pages 297-300.
[4]. Malas N, Ortiz-Aguayo R, Giles L, Ibeziako P. Pediatric Somatic Symptom Disorders. Curr Psychiatry Rep. 2017; 19(2):11.
[5]. Consolisg. Pathomimias In The Child. J Pediatr Puériculture. 1997; 10:474-478.
[6]. Abilkassem R, Dini N, Ourai H And Al. Pathomimia Of Children: About An Observation. Pan Africa Medical Journal 2013; 14: 23.

[7]. Hlal H, Barrimi M, Kettani N And Al. Factitious Disorder And Skin Picking: Clinical Approach: A Case Report. L'encephale 2014, Volume 40, Issue 2, Pages 197-201.
[8]. Gieler U, Consoli Sg, Tomas-Aragones L, Linder Dm. Self- Inflicted Lesions In Dermatology: Terminology And Classification, A Position Paper From The European Society Fordermatology And Psychiatry. Acta Derm Venereol 2013; 93:4-12.
[9]. Harth W, Taube Km, Gieler U. Factitious Disorders In Dermatology. J Dtsch Dermatol Ges 2010; 8:361-72.
[10]. Limosin F, Loze Jy, Rouillon F. Clinical And Psychopathology Of Artificial Disorders. Med Intern Ann. 2002; 153(8): 499-502.
[11]. Kisra H, Benyoussef K, Manali A, Raddaoui K, And Al. Artificial Disorders In Dermatology. Med Magh. 2004; 121:15-18.
[12]. World Health Organization (1993) International Classification Of Diseases, Tenth Edition (Icd-10/Icd-10). Masson, Geneva.
[13]. Dsm-5. Diagnostic And Statistical Manual Of Mental Disorders, Publié Par L'american Psychiatric Association 2013.
[14]. Hosteing S, Nougué J. Mazereeuw J Stereotypical Child Pathomimic: 3 Cases. Annal Of Dermatology And Virology (Elsevier Masson), 2014: Vol 141 - N° 12s, P. S338-S339.
[15]. Uçmak D, Harman M, Meltemakkurt Z. Dermatitis Artefacta: A Retrospective Analysis. Cutan Ocul Toxicol. 2014 ; 33 (1) : 22-7 ;
[16]. Sokumbi O, Comfere Ni, Mcevoy Mt, And Peters Ms. Bullous. Dermatitis Artefacta. Am J Dermatopathol. 2013; 35 (1): 110-2.
[17]. Nielsen K, Jeppesen M, Simmelsgaard L, And Al. Self-Inflictedskin Diseases: A Retrospective Analysis Of 57 Patients With Dermatitis Artefacta Seen In A Dermatology Department. Acta Derm Venereol. 2005; 85 (6): 512-5.
[18]. Rodríguez-Pichardo A, Hoffner Mv, García-Bravo B, Camachofm. Dermatitis Artefacta Of The Breast A Retrospective Analysis Of 27 Patients (1976-2006). J Eur Acad Dermatol Venereol.2010; 24 (3): 270-4.
[19]. Bedard-Thomas Kk, Bujoreanu S, Choi Ch, Ibeziako Pi. Perception And Impact Of Life Events In Medically Hospitalized Patients With Somatic Symptom And Related Disorders. Hosp Pediatr.2018; 8 (11):699-705.
[20]. Gattu S, Rashid Rm, Khachemoune A. Self-Induced Skin Lesions: A Review Of Dermatitis Artefacta. Cutis. 2009; 84 (5): 247-51.
[21]. Mcfarlane Fa, Allcott-Watson H, Hadji-Michael M, And Al. Cognitive-Behavioral Treatment Of Functional Neurological Symptoms (Conversion Disorder) In Children And Adolescents: A Case Series. Eur J Paediatr Neurol. 2019; 23(2):317-328.