Cutaneous Artifactual Disease Represented as Recurrent Toxic Epidermal Necrolysis

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PRACTICE **POINTS**

- It is important to consider an underlying psychiatric disorder (eg, factitial disorders) in dermatologic patients, even when an exogenous cause can be identified.
- On occasion, dermatologic disease is best treated and prevented with routine psychiatric care and psychotropic therapy.

To the Editor:

Lyell[1] coined the term *cutaneous artifactual disease* to describe the spectrum of factitious disorders associated with skin presentations. Interestingly, Lyell was the first to name *toxic epidermal necrolysis* (TEN).[2,3] We present a rare case of factitial TEN, a dangerous and life-threatening manifestation of factitial disease.

A 49-year-old homeless man with a history of Stevens-Johnson syndrome (SJS)/TEN from trimethoprim-sulfamethoxazole (TMP-SMX) was admitted on 4 separate occasions over an 18-month period for recurrent exposure to the medication producing SJS/TEN. Originally, this patient was given TMP-SMX for a skin infection and 10 days later presented with 15% body surface area (BSA) involvement of SJS/TEN. He was successfully treated with intravenous immunoglobulin (IVIg) in the burn intensive care unit (BICU) and discharged. Several months later, the patient was given TMP-SMX for a leg infection by a different clinic. He was admitted to the BICU with 40% BSA, treated with IVIg, and survived. Eight months later, the patient was again admitted to the BICU with 30% BSA and treated with IVIg; however, this admission required intubation due to complications secondary to volume resuscitation. He was evaluated by psychiatry and confessed to purposely seeking TMP-SMX, stating that he "liked the food and care in the hospital." He was diagnosed with factitial disorder and given a referral for further treatment at an outpatient facility. Two months later, the patient was again admitted to the BICU after taking a single dose of TMP-SMX obtained from a "friend." He had 10% BSA with conjunctival involvement and was again successfully treated with IVIg. He was discharged with the state psychiatric system for further treatment and evaluation.

Factitial disease in dermatology is difficult to diagnose. Its incidence is unknown, as only case reports exist in the literature. In factitial disease, patients "perform self-mutilating and clinically relevant damage to themselves without the direct intention of suicide."[4] Harth et al[4] described

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The authors report no conflict of interest.
The opinions expressed here are the private views of the authors and do not represent the official position of the US Department of the Air Force or the US Department of the Army.
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3 subcategories of factitious disorders: dermatitis artefacta syndrome, dermatitis para-artefacta syndrome, or malingering. Dermatitis artefacta syndrome is "a dissociated self-injury or behavior where the patient unconsciously simulated disease with intention to be cared for as a patient."[4] Dermatitis para-artefacta syndrome was described as a disorder of impulse control in which a patient will produce or manipulate a specific dermatosis presentation. The patient usually admits to doing it in a semiconscious state. Dermatitis artefacta and dermatitis para-artefacta differ from malingering in that malingering patients knowingly fake symptoms for external gain, which can be monetary or the avoidance of responsibility.[4] More familiar examples to dermatologists of factitial disease include factitial panniculitis,[1] direct applications of caustic agents to the skin, and excoriations from instruments or fingernails.[4,5]

This case illustrates the difficult and potentially dangerous nature of factitial disorders, specifically dermatitis para-artefacta syndrome. Our patient was intensely preoccupied with the outcome of being a patient in a hospital. Our patient sought out a medication from multiple providers to produce a deadly and severe life-threatening reaction. If his main intentions were solely to obtain a bed and 3 square meals a day, then malingering would have represented his factitial disease. However, his main intent was to be seen as a patient, and then doted on and cared for by medical professionals in a hospital setting. From this assessment, the patient's behavior would fall under the factitial disorder of dermatitis para-artefacta syndrome.

Factitious disorders pose immense challenges for diagnosis and treatment. It is prudent for physicians to learn to recognize patterns of history and examination that do not coincide. The first step in treatment is the recognition and early involvement of psychiatry to aid in curbing this behavior. Remission of factitial disorders can be induced with proper diagnosis and treatment. Patients with the highest chance of remission are those with treatment centered on behavioral therapy in conjunction with psychotropic medications.[1]

REFERENCES

1. Lyell A. Cutaneous artifactual disease. *J Am Acad Dermatol*. 1979;1:391-402.
2. Palmieri TL, Greenhalgh, DG, Saffle JR, et al. A multicenter review of toxic epidermal necrolysis treated in U.S. burn centers at the end of the twentieth century. *J Burn Care Rehab*. 2002;23:87-96.
3. Lyell A. Toxic epidermal necrolysis: an eruption resembling scalding of the skin. *Br J Dermatol*. 1956;68:355-361.
4. Harth W, Gieler U, Kusnir D, et al. Primarily psychogenic dermatoses. In: *Clinical Management in Psychodermatology*. 1st ed. Leipzog, Germany: Springer-Verlag Berlin Heidelberg; 2009:11-19.
5. Sanmartin O, Requena C, Requena L. Factitial panniculitis. *Dermatol Clin*. 2008;26:519-527.