

THE CLINICAL PICTURE

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The Clinical Picture

A 40-year-old woman with excoriated skin lesions



FIGURE 1.



FIGURE 2.

A 40-YEAR-OLD WOMAN presents to the clinic with multiple excoriated lesions over her chest, arms, abdomen, and upper back (FIGURE 1, FIGURE 2). The lesions have been present for many years; a few of them show signs of recent bleeding.

She denies any history of itching, insect bites, exposure to new medications or jewelry, allergies, recent change in medications, travel, or intravenous drug abuse.

A review of systems finds no liver, kidney, or heart disease. On examination, we find multiple scattered, weeping, crusted ulcerations, hyperpigmented macules and papules, and atrophic scars in different stages of healing on the upper chest, arms, abdomen, and upper back.

Q: Which is the most likely diagnosis?

- Allergic contact dermatitis
- Xerosis
- Dermatotillomania
- Folliculitis
- Infestation (scabies)

A: **Dermatotillomania**, ie, pathologic skin picking, is the correct diagnosis. On further questioning, the patient reveals that the wounds have been self-inflicted over many years, starting in her adolescence. The wounds are located only in areas she can reach. She admits that social and emotional stressors had made the condition significantly worse and that lately she had lost control of her skin-picking. She denies nail-biting, trichotillomania, or obsessive-compulsive behavior.

As for the other possible diagnoses:

Allergic contact dermatitis occurs when contact with a particular substance elicits a hypersensitivity reaction. This reaction is of the delayed type (type IV). The affected individual can develop skin erythema and swelling with vesicles that are intensely pruritic at the contact site. The erythema may become evident hours after exposure, or not until weeks later, which can make the diagnosis difficult at times.

Our patient's lesions were not pruritic, and she denied recent exposure to allergens.

Xerosis. Xerotic (dry) skin is usually rough, with fine scales and fissures. Xerosis can affect people of all ages and is often more intense during the winter. It affects mainly the arms, legs, and hands. Patients note pruritus, which can be treated with liberal use of emollients and tepid water baths.

Our patient's lesions were scarred, hyperpigmented, and nonpruritic.

Folliculitis is a superficial infection of the hair follicle that presents as an erythematous pustule on the extremities, buttocks, or scalp. The pustule can be tender to palpation and can progress to an abscess that requires incision and drainage and intravenous antibiotics. A moist environment and poor hygiene are predisposing factors. *Staphylococcus aureus* is the culprit in most cases.

Our patient's lesions were on the chest and upper back, where hair follicles were sparse or absent, and there was no erythema or tenderness.

Scabies is a skin infestation with *Sarcoptes scabiei* mites, which burrow in the skin and cause intense pruritus, especially at night. Scabies usually affects the sides and webs of the fingers and skin folds. Sexual contact is a common way of transmission; however, transmission can also occur by sharing beds and towels.

Patients with dermatotillomania lack intense pruritus, and skin-picking occurs during the day, while the patient is awake.

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SELF-INFLICTED WOUNDS

Pathologic skin-picking, neurotic excoriation, excoriated acne, or dermatotillomania results from scratching, picking, gouging, or squeezing of one's skin via teeth, fingernails, tweezers, or other objects.¹⁻³ Lesions are usually found on skin that the patient can easily reach, such as the face, chest, upper and lower extremities, and upper back.⁴

The prevalence of pathologic skin-picking is estimated at 2% in dermatology patients.⁵ The overall prevalence of psychiatric disorders in all dermatology outpatients is estimated at 30% to 40%. Women outnumber men with this disorder.⁶

Dermatotillomania is thought to be on the spectrum of obsessive-compulsive disorder, in which patients exhibit impulses and compulsions.⁵ It starts in childhood or early adulthood, with an average lifetime duration of 21 years.⁷ It is usually associated with anxiety, depression, obsessive-compulsive traits, eating disorders, body dysmorphic disorders, or hypochondriasis. Psychosocial stress is the main trigger. Patients report feelings of tension and stress before picking and relief while picking; there is no suicidal ideation.⁸

Treatments are both pharmacologic and behavioral.⁹ Cognitive behavioral therapy and habit reversal therapy have each been successful when used alone.⁸ In addition, several case reports¹⁰ and double-blind studies^{11,12} have shown that treatment with a selective serotonin-reuptake inhibitor (SSRI) can reduce pathologic skin-picking.^{13,14} However, SSRIs have also been reported to induce or aggravate this behavior in patients with underlying mild skin-picking and a family history of skin-picking.¹⁵ Thus, it is pertinent to extract a detailed history from the patient before prescribing an SSRI.

We referred our patient for behavioral therapy and prescribed fluoxetine (Prozac) 20 mg daily. She showed improvement in symptoms in 4 weeks and has since stopped skin-picking completely. ■

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