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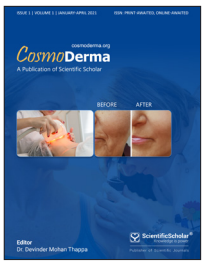

Perspective

Self-induced skin lesions in dermatology

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ABSTRACT

Self-induced skin lesions comprise lesions on skin, mucosa, and/or appendages, which are produced by the patients themselves and not being a consequence of any underlying physical or mental health disorder. These include impulse control disorders such as hesitation cuts, various compulsive behaviors such as trichotillomania, as well as body dysmorphias. These disorders are not infrequent in dermatological practice and perplex the clinician not only with their bizarre presentations but also challenging in terms of management of the "psyche" along with the "skin." The present article aims to bring to perspective a dermatological peek and view into the self-harm domain in psychodermatology.

Keywords: Self-induced dermatoses, Psychodermatology, Psyche and skin.

Self-induced skin lesions can be defined as any skin lesions, which are actively and directly produced by the patient on his/her skin, mucosa or integuments that are not better explained as a consequence of another physical or mental disorder.[1] Simply put; these are dermatological consequences of a pathological behavior. The terminology aims to encompass disorders where the behavior is hidden with or without incentive (e.g., malingering or factitious disorders) where the abnormal behavior is accepted by the patient either out of "compulsion" (e.g., trichotillomania and acne excoriee) or out of "impulse" (e.g., hesitation marks by repetitive self-cutting). Somewhere on the spectrum lies the body dysmorphic disorder where there is pre-occupation with appearances and the incessant quest for youth, the Dorian Gray Syndrome. As per definition, aesthetic procedures also technically conform to the definition of deliberate self-harm and are considered an intermediate group; however, the underlying motivator could be a mental health disorder such as depression or anxiety. While it is lucrative to define and classify these entities into factitious disorders, compulsive and impulsive disorders or body-modifying behaviors for the sake of academic fruition, the concept of self-harm is practically arduous in both diagnosis and management. The quintessential patient walking in with a bizarre clinical picture and a bulky documentation of prior vain investigations and management speaks volumes about the perplexity of management and potential imitation of many generic dermatoses.[2]

While the "splitters" will name more entities and the "lumpers" will group them, a dermatologist needs to identify the morphology as self-induced. In the cases of compulsive and impulsive disorders, diagnosis is often straightforward, and a history of self-infliction of lesions is often divulged by patients themselves such as in most cases of acne excoriee, trichotillomania, and onychophagia. However, the factitious group of disorders is often a diagnostic challenge. Although the bizarre and not-so-plausible, dramatic clinical presentation is a soft pointer, it is crucial to not miss out organic disorders by dismissing what you do not comprehend as a textbook dermatosis.

There have been multiple cases in both literature and practice where a misdiagnosis of dermatitis artefacta has been made in cases such as trigeminal trophic syndrome or rare IgG4-related disorders.[3,4] The converse is also true: Dermatitis artefacta had been diagnosed as entities such as pemphigus or pyoderma gangrenosum for years before realizing the real picture.[5,6] What helps to diagnose factitious disorders in a practical sense is beginning one's observation right from the point when the patient enters the consulting: General demeanor, apathy, the la belle indifference, and empty histories with no rational explanation on how the lesions appeared, inability to explain the evolution of lesions, and presence of bizarre morphologies at accessible body sites. Apart from these, there are new self-induced disorders based on social media challenges and peer pressure, the so-called "digital dermatoses" such as Kylie Jenner lip challenge, salt and ice challenge, deodorant challenge, eraser challenge, fire challenge, and hot water challenge.[7] By getting influenced from these trends, teenagers often land up scalding or bruising their skin.

It is important to identify why rather than how self-induced dermatoses to manage them. The psyche is complex, and management requires an interdisciplinary approach involving dermatologists, psychologists, and psychiatrists. Recognition of these disorders should be a part of the training curriculum as dedicated courses and managed in an ideal setup of a psychodermatology clinic. While the latter is an evolving concept, every clinician can imbibe qualities of patient, non-judgmental, and empathetic behavior while dealing with such cases. Referral to psychiatry is never a cakewalk: There are multiple barriers including denial, stigma, and attributing a skin disease to be the cause of all agonies to name a few. Skin-directed therapies usually involve appropriate topicals and management of wounds by dressings and/or antibiotics. Psychotherapy and pharmacotherapy should be carried out in liaison with the psychiatry department along with emotional support by all attending doctors throughout the patients' journey. Hence, self-induced skin lesions need to address the psyche behind self-infliction and not just skin lesions!

Ethical approval

Institutional Review Board approval is not required.

Declaration of patient consent

Patient's consent is not required as there are no patients in this study.

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Conflicts of interest

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Use of artificial intelligence (AI)-assisted technology for manuscript preparation

The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

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