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UNMASKING ARTEFACTUAL LESIONS IN LEPROMATOUS LEPROSY: A RARE CASE OF COEXISTENCE

Dermatology

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ABSTRACT

Background: Dermatitis artefacta (DA) is a psychocutaneous condition characterized by deliberate, self-inflicted lesions, often concealed by patient denial. Its concurrence with lepromatous leprosy is extremely uncommon and can obscure classical clinical features, creating significant diagnostic difficulty. **Case:** We report a 20-year-old woman who presented with multiple skin lesions of diverse morphology. Examination revealed atrophic patches on the thighs, bullae and erosions over the forearms, and dusky plaques on the dorsal hands. Additionally, she displayed classical signs of advanced lepromatous leprosy, including diffuse infiltration, madarosis, saddle-nose deformity, and widespread infiltrated plaques and nodules. Slit-skin smears and histopathology confirmed multibacillary lepromatous leprosy. However, the peculiar morphology and localization of erosions and bullae to easily accessible areas raised suspicion of DA, which was reinforced following psychosocial evaluation. The patient was commenced on multidrug therapy for leprosy, wound care, and referred for psychiatric intervention. **Discussion:** DA superimposed on leprosy may mimic lepra reactions, drug-induced eruptions, or secondary infections, risking misdiagnosis and inappropriate therapy. Clinical recognition of atypical distribution and morphology, along with clinicopathological correlation, is crucial. Multidisciplinary management, integrating dermatology, psychiatry, and microbiology, is essential. **Conclusion:** Awareness of DA coexisting with lepromatous leprosy is critical. Early recognition avoids unnecessary interventions and enables holistic care tailored to both infectious and psychiatric dimensions.

KEYWORDS

Dermatitis artefacta, leprosy, psychodermatology, multibacillary leprosy, self-inflicted lesions

INTRODUCTION

Dermatitis artefacta (DA) is a challenging psychocutaneous disorder in which patients create lesions on their own skin, typically driven by psychosocial stressors or underlying psychiatric illness \[1,5]. Lesions may present in bizarre shapes, have sharp margins, and are usually located on accessible parts of the body. Patients consistently deny responsibility, often leading to repeated consultations and unnecessary interventions \[3].Leprosy, caused by *Mycobacterium leprae*, remains a significant public health concern in many endemic countries. Lepromatous leprosy, representing the multibacillary pole of the spectrum, is marked by diffuse infiltration, nodular lesions, systemic involvement, and deformities such as madarosis and saddle-nose deformity \[2,6]. Timely diagnosis and treatment are essential to prevent complications and transmission.

Reports of DA coexisting with leprosy are exceedingly rare.
Artefactual lesions may mimic lepra reactions (Type 1 reversal or Type 2 erythema nodosum leprosum), secondary infections, or druginduced eruptions, thereby confounding diagnosis. The lack of awareness can lead to inappropriate therapy, worsening morbidity, and unnecessary investigations.

We present a rare case of DA occurring in a young woman with advanced lepromatous leprosy, highlighting diagnostic pitfalls and emphasizing the role of multidisciplinary care.

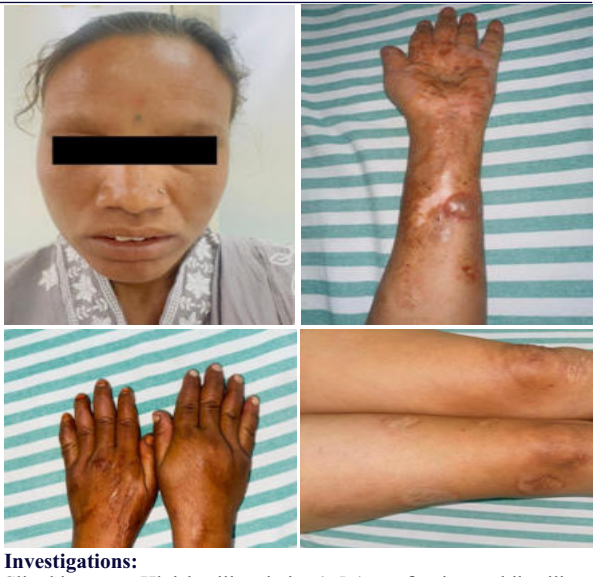
CASE REPORT

A 20-year-old woman presented to our outpatient dermatology service with a history of multiple skin lesions evolving over six months. She described painful erosions and bullous eruptions on her forearms, nonhealing ulcers, and disfiguring facial changes.

Clinical Examination:

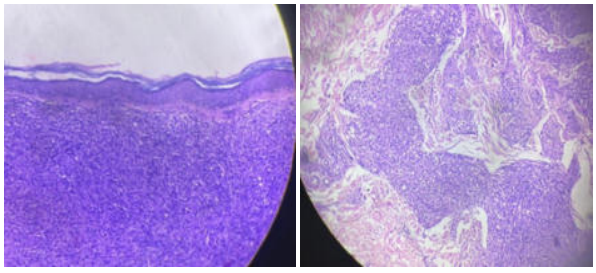
Forearms: Multiple tense bullae, erosions, and crusted plaques with sharp borders. Thighs: Well-defined atrophic patches, some with post-inflammatory pigmentation.
Hands: Dusky erythematous plaques over the dorsal surfaces. Face and trunk: Diffuse infiltration, bilateral madarosis (loss of eyebrows), saddle-nose deformity, and widespread infiltrated hypopigmented plaques and nodules.

Neurological examination revealed glove-and-stocking anesthesia, with thickened peripheral nerves palpable along the ulnar and common peroneal distribution.



Investigations:

Slit-skin smear: High bacillary index (>5+), confirming multibacillary disease.
Histopathology: Diffuse dermal infiltration with foamy macrophages packed with acid-fast bacilli, consistent with lepromatous leprosy. Routine labs: Within normal limits.



Clinical dilemma: The bullae and erosions on the forearms were atypical for leprosy, both in morphology and distribution. Their restriction to easily accessible areas and bizarre, sharply demarcated shapes suggested self-infliction. A psychiatric consultation was

sought.

Psychiatric evaluation: The patient disclosed psychosocial stressors, including family conflict and feelings of neglect. She admitted to repeated manipulation of lesions, confirming DA.

Management:
WHO multidrug therapy for multibacillary leprosy (rifampicin, dapsone, clofazimine). Local wound care and infection prevention.

Psychiatric counseling with initiation of behavioral therapy and psychosocial support.Regular dermatology-psychiatry follow-up.

DISCUSSION

This case highlights the diagnostic complexity of DA superimposed on lepromatous leprosy.

Dermatitis artefacta in dermatology:
DA is a form of factitious disorder presenting with polymorphic, selfinflicted lesions. Patients deny self-harm, making diagnosis dependent on clinical suspicion \[1,3,5]. Common features include:

- Lesions of bizarre shape or geometric outline
- Sharp demarcation
- Presence on accessible sites (forearms, thighs, face)
- Inconsistent history and rapid changes in morphology

Lepromatous leprosy overview:
At the opposite end of the leprosy spectrum, lepromatous disease is characterized by diffuse infiltration, nodular lesions, systemic spread, and deformities \[2,6]. Lepra reactions are common and can manifest with erythematous nodules, pustules, or systemic symptoms.

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