Research Paper Medical Science

Psychogenic Skin Excoriation (Skin Picking) : Case Report

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ABSTRACT

Compulsive skin picking is a new disorder called Psychogenic Excoration or Skin Picking Disorder coined in DSM-5. It is known to be seen in patients with other mental illnesses as well as a stand alone psychiatric disorder on its own. The disorder has been reported in numerous anecdotal case reports and case studies and needs further research. Here we report a case of 12 year old girl with the disorder who responded well to medical treatment

KEYWORDS Psychogenic excoriation, skin picking, skin picking disorder.

Introduction

Compulsive skin picking is characterized by excessive scratching or picking of normal skin or skin with minor surface irregularities. It is also known as psychogenic excoriation, neurotic excoriation, acne excoriée and dermatotillomania. The prevalence is estimated in range of 1.4 – 5.4% and is more common in women in late teens to 30s.[1,-3] It was first described by Erasmus Wilson in 1875.[4] Skin lesions caused by this disorder have well-demarcated borders and include areas of the body that are easily reachable by the patient. Common sites involved are extensor surfaces of arms, anterior thighs, the face, fingers, and upper back.[5,6] Important complications include infections, lesions, scarring, and serious physical disfigurement.[7] Few complications can be life threatening like injury to major blood vessels like facial and carotid in patients using sharps for skin picking.[8] Subjects with SPD exhibited significantly reduced fractional anisotropy in tracts distributed bilaterally, which included the anterior cingulate cortices.[9] Here we report a case of skin picking behaviour in a 12 year old girl.

Case Report

12 years old Hindu female child, studying in 7th standard was brought by her mother to our out patient department with chief complaints of difficulties in facing social settings since 6 years and excessive picking of skin of fingers of hands since 2 years.

According to patient and mother, patient was alright till 6 years back, while she was studying in kindergarten and there was a teacher in her school who used to shout and hit children. So she used to be very fearful of that teacher and gradually started experiencing difficulties while facing other teachers and strangers also. She used to have feelings of ghabarahat i.e. her heart used to beat at faster rate, also she would get tremors and increased sweating. These features would last for about 15-20 minutes every time she had to face an authoritative figure or strangers. Also these feelings would be present while giving oral exams. But she would be comfortable playing with children of her age and was comfortable with parents. In spite of these complains somehow she managed to pass her exams and continued going to school. She used to be quiet at school not talk much with teachers or ask any queries.

Two and half years back her elder brother got married and stressors at home started due to constant altercation between his wife and patient's mother over trivial family matters related to household work. Also at the same time her brother developed symptoms of schizophrenia, requiring admission for 1 month. Due to increased stress at home in that one month period, patient started picking skin from area near the nail beds of hands. Patient used to get relief from the stress by this action. So she gradually was doing it more frequently and used to spend about 3 hours of a day doing so. She experiences extreme uneasiness if she resisted doing so. Due to this behaviour the skin remains constantly eroded and the lesions caused by it are not pleasant site. So she used to feel guilty about her behaviour. She had also started taking leave from her school and has been irregular. She has not been able to focus in her studies since last 1- 1.5 years, her scores being degrading. She avoids family functions and going to relatives' house as she is ashamed of her skin lesions and is very much apprehensive of what answer to give for others' concerns.

There were no other complaints like persistent sadness of mood, ideas of helplessness and worthlessness, hearing voices inaudible to others, muttering and gesticulating behaviour. There were no sleep or appetite disturbances. There was no history of psychiatric illness in her family. She did not suffer from any other medical or surgical illness. No significant abnormalities were noted on general and systemic examinations apart from skin lesions on fingers of hands. On mental status examination (MSE) patient was sitting on chair with head down, was restless constantly fidgeting with her fingers. Eye to eye contact was initiated but not maintained. Mood she conveyed was anxious. No other abnormalities were found on MSE.

We diagnosed her as having excoriation (skin-picking) disorder as per diagnostic and statistical manual (DSM-5). We started her tab. Fluoxetine 10mg in morning after breakfast and followed her after 15 days. Also she was taught relaxation

technique. Behaviour therapy was used in form that she was asked to keep her hands wrapped in cloth so she could not pick at skin. She was being awarded as per amount of time she could resist at picking the skin. On follow up she showed some improvement, she had reduced anxiety and decreased the time she spent in picking at skin. Her fluoxetine was increased to 20mg.

She is regularly following up in our O.P.D. and is well maintained on above treatment. She is now able to focus in her studies and also started going to relatives' house and also can ask questions to teachers. She is feeling confident now.

Discussion

Skin picking disorder has been historically classified as as an impulse-control disorder not otherwise specified, a stereotypic movement disorder,[10] an obsessive-compulsive spectrum disorder,[1] a behavioral addiction,[11] and a form of self-injurious behavior[12] even in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) it does not have separate category. But DSM-5 has included it separately in the chapter of obsessive compulsive and related disorders.[13] It is found along with other anxiety disorders like agoraphobia, social or specific phobia, obsessive compulsive disorder, posttraumatic stress disorder, panic disorder, or generalized anxiety disorder. Also it is seen with major depression, bipolar disorder and dysthymia.[1] Treatment options include selective serotonin reuptake inhibitors (SSRIs) (eg. sertraline and escitalopram), benzodiazepines for short-term therapy to reduce anxiety or tricyclic antidepressants such as doxepin. Other option is a mood stabilizer, such as lamotrigine, lithium, divalproex, topiramate and carbamazepine, There have been some reports of antipsychotics like haloperidol, aripirazole as augmenting agents. N-acetylcysteine also has been found useful.[14-21]

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