Dermatitis Artefacta, an unusual presentation.

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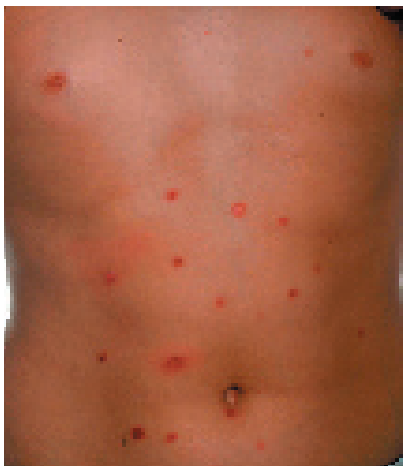
Abstract: A healthy 11-year-old boy presented with skin lesions on the abdomen. After elaborate history, examination and investigations diagnosis of dermatitis artefacta was made. He denied self harm and lesions improved with symptomatic treatment. He is under close observation by his family and dermatologist and no new lesions have developed.

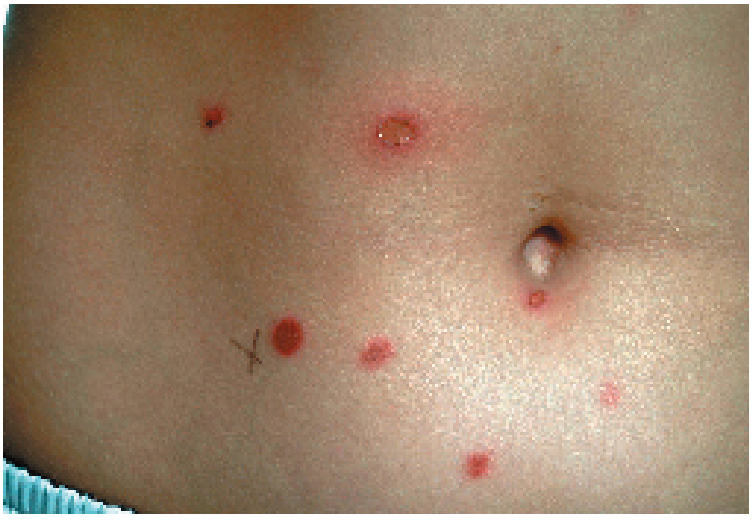
Keywords: Dermatitis artefacta, Artefactual skin lesions

Dermatitis artefacta is uncommon in children. Saez et al have reported a frequency of 1:23,000. This condition is commoner in teenager girls and lesions are usually seen on exposed part of the body. We report a case in an 11year old boy with lesions on the abdomen, which is a rare presentation of a rare condition.

Case report

An 11 yr old boy presented to the paediatric ward with an asymptomatic rash on the abdomen, which progressed over 7 days to involve his thighs. He was unable to give a detailed history of the evolution of these lesions. He had been ice camping and was bitten by an insect on the foot about 5 weeks earlier. He was otherwise well and was not on any medication. Past medical history and family history were unremarkable.





Figures 1&2. Macular rash on abdomen with fairly symmetrical distribution.

The rash was macular, bright red in colour, in different stages of evolution and each lesion was fairly symmetrical (Figures 1&2). Though the lesions looked inflamed he did not complain of pain and appeared unconcerned. No rashes were noted on the back. The remaining physical examination was unremarkable. The differential diagnosis included vasculitis, viral rash and dermatitis artefacta.

Full haematological screening, *Borrelia burgdorferi* antibodies, biochemical tests and viral serology were negative. A dermatologist advised a punch biopsy which showed inflammation due to a non-specific ulcer, possibly traumatic resulting from burn. The clinical picture fitted very well with cigarette burn.

The boy denied self-harm or harm from friends or family. His family accepted the diagnosis. He was treated symptomatically and the lesions healed leaving behind a pigmented scar and no new lesions have developed. He is under close observation by his family and is under regular follow up by the dermatologist.

DISCUSSION

In dermatitis artefacta the patient produces skin lesions consciously or unconsciously to satisfy a psychological need that is not consciously understood[1]. Although any age group may be affected, a mean age of 14 years has been reported in paediatric populations[2,3] . Female preponderance with female: male ratios ranging from 3:1 to 7:1 to 20:1 have been noted in different studies[2,3,4,5]. The lesions are on the easily accessible parts of the body with head and neck being the commonest followed by limbs. Superficial erosions are the most common type of artefactual skin lesions[3]. Rogers et al studied 32 cases and only one among them had lesions on the abdomen, which is habitually covered.

Age and gender of the patient, "hollow" history, bizarre morphology of lesions, fully evolved lesions at presentation, healing in a short time without any treatment, indifference of the patient when the lesions are unsightly and painful, impatience of attendant family and a thick file of prior investigations suggest the diagnosis of dermatitis artefacta[5]. It is important to consider other dermatological and psycho dermatological conditions before making the diagnosis[5].

Once the diagnosis is made direct confrontation with the child should be avoided but the child should be made aware that it is known what they are doing by telling them the cause of such lesions is injury. Parents should be told in detail about the diagnosis and management plan. Most patients deny self-harm but its recognition by medical staff is important in order to initiate treatment until patients accept psychiatric consultation[3,5]. When psychiatric referral is refused the use of psychotropic drugs is helpful and appropriate[4,5,6]. Most of these children improve with change in life situation and due to developmental maturation. As this condition waxes and wanes with circumstances in patients' life follow up by a dermatologist for supervision and support is advisable[5].

The case reported is not only uncommon with respect to age, gender and site, but the scattered distribution of lesions on abdomen and thighs, lesions being in different stages of development, history of insect bite and no significant past or family history made us think of organic cause as first differential diagnosis. It is important to remember that the mode of presentation can be varied and unless the possibility is specifically considered diagnosis may prove difficult.

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REFERENCES

1. Koblenzer CS. Neurotic excoriations and dermatitis artefacta. *Dermatol Clin* 1996; 14:447-445.

2. Libow JA. Child and adolescent illness falsification. *Pediatrics* 2000; 105:336-342.

3. Rogers M, Fairley M, Santhanam R. Artefactual skin disease in children and adolescents. *Australas J Dermatol* 2001; 42:264-270.

4. Saez-de-ocariz M, Orozco-Covarrubias L, Mora-Magana I, Duran-McKinster C, Tamayo-sanchez L, Gutierrez-Castrellon P, Ruiz-Maldonado R. Dermatitis artefacta in pediatric patients: experience at the national institute of pediatrics. *Pediatr Dermatol.*2004; 21:205-211.

5. Koblenzer CS. Dermatitis artefacta. Clinical features and approaches to treatment. *Am J Clin Dermatol* 2000; 1:47-55.

6. Gupta MA, Gupta AK. The use of antidepressant drugs in dermatology. *J Eur Acad Dermatol Venereol.*2001; 15:512-518