

Journal of Mind and Medical Sciences

Volume 2 | Issue 2

Article 7

2015

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Recommended Citation

Tampa, Mircea; Sarbu, Maria Isabela; Matei, Clara; Benea, Vasile; and Georgescu, Simona Roxana (2015) "Common Dermatoses in Patients with Obsessive Compulsive Disorders," *Journal of Mind and Medical Sciences*: Vol. 2 : Iss. 2 , Article 7.

Available at: <http://scholar.valpo.edu/jmms/vol2/iss2/7>

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Common dermatoses in patients with obsessive compulsive disorders

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Running title: Dermatoses in obsessive compulsive disorders

Keywords: Factitious disorders, obsessive-compulsive disorders, acne excoriee

www.jmms.ro 2015, Vol. II (issue 2): 150- 158.

Date of submission: 2015-02-20; **Date of acceptance:** 2015-04-17

Abstract

Obsessive-compulsive disorder is a chronic, debilitating syndrome, consisting of intrusive thoughts- which are experienced as inappropriate by the patient and are producing anxiety- and compulsions, defined as repetitive behaviours produced to reduce anxiety. While patients with obsessive-compulsive disorder typically have xerosis, eczema or lichen simplex chronicus, as a result of frequent washing or rubbing their skin, several other disorders which are included in the group of factitious disorders have also been associated with obsessive-compulsive disorder. A close collaboration between the dermatologist and the psychiatrist is therefore mandatory in order to achieve favourable outcomes for these patients. The aim of the article is to present the most frequent dermatological disorders associated with obsessive-compulsive disorder and to look over some of the rare ones.

Introduction

The skin and the nervous system are connected through their common origin, both of them developing from the neural plate in the ectoderm. They have common neuromodulators, peptides, cytokines, glucocorticoids and other molecules. On the other hand, behavioural habits which determine actions like sun exposure or exposure to animals and plants are also brain regulated and involved in the occurrence of several dermatoses. As a result, several psychiatric conditions can trigger various dermatoses and various dermatoses can lead to psychiatric comorbidities (1- 3).

The connection between the skin and the nervous system was noticed even from the antiquity. Hippocrates mentions in his writings that fear makes the heart beat faster and people start to sweat (4). He also mentions that some people pluck out their hair when they are stressed. Aristotle believed that the brain and the body were inseparable entities (3, 5). Enrico Morselli described body dysmorphic disorder in 1891 as preoccupation with an imagined or slight defect in appearance. The term dysmorphia was inspired from the Histories of Herodotus regarding the myth of the ugliest girl in Sparta. According to this story the dysmorphic child became the fairest girl in Sparta and married the king after a nurse prayed for her every day (6). Alopecia areata, pruritus, delusions of parasitosis were first described as “skin neurosis” in 1857 by William Wilson (5).

Discussion

About one third of the patients addressing dermatology clinics throughout the world present psychological comorbidities. Therefore, it is important for the dermatologist to be able to differentiate between the various disorders. The psychocutaneous disorders can be divided into four groups: psychophysiological disorders, where cutaneous disorders are aggravated by stressful factors (seborrheic dermatitis, psoriasis, hyperhidrosis); primary psychogenic disorders, where the skin lesions are self-induced; secondary psychiatric disorders, where the psychiatric affliction is determined by the presence of the skin disease and patients often suffer from depression, anxiety or social phobia; cutaneous sensory

conditions, where patients feel itching, burning, stinging sensations without having any skin disorder (Glossodynia, vulvodinia) (1, 7).

Primary cutaneous disorders can also be divided into four categories: delusional, factitious, somatoform and compulsive (1). Obsessive-compulsive disorder (OCD) is a chronic, debilitating syndrome, consisting of intrusive thoughts which are experienced as inappropriate by the patient and are producing anxiety, and compulsions, defined as repetitive behaviours produced to reduce anxiety (7, 8). If the patient tries to resist the compulsion, the obsessive urge increases and anxiety becomes greater (9). Frequent dermatological findings in OCD include xerosis and eczema, as a result of compulsive washing and lichen simplex chronicus in patients with compulsive rubbing. However, several other skin disorders included in the group of factitious disorders are often associated with OCD (1, 9).

Skin picking also known as neurotic excoriations or dermatillomania accounts for about 2% of consultations in dermatology departments. Skin picking is frequent in the general population and it should only be considered pathological if it is chronic and leads to important dysfunctions or disfigurement. The lesions occur as a result of picking, scratching, rubbing, pulling the skin or even after the use of sharp objects such as tweezers. The patients admit their role in producing the lesions but they cannot stop their behaviour. It is more frequent in females and it usually affects patients between 30 and 50 years. The picking episode is often preceded by a stressful event. Patients report feeling tension before the picking episode and relief or even pleasure after. In some situations the picking episode can last for hours thus affecting the daily activity or work of the patients. Sometimes patients describe the lesions as being itchy, in which case the diagnosis is more difficult, since other dermatoses must be excluded. On clinical examination (Fig. 1-4) the new lesions appear as angulated erosions covered by crusts while older lesions present as hypopigmented or hyperpigmented scars. In severe cases prurigonodularis lesions, characterized by extremely pruritic nodules of various diameters, can also occur. Patients may present a few lesions or several hundred lesions and they can be limited to one area of the body or they can be distributed to several areas, sparing the regions that cannot be reached. They

are usually located on the extensor surfaces of the extremities, upper back and face. Patients often feel shame and embarrassment and try to hide the lesions. Skin picking has been associated with trichotillomania in 10% of the patients and OCD in up to 52% of patients (10).

Acne excoriee is a form a skin picking in which the lesions are located on the face. It is also more frequent in females. Patients pick on acne lesions or small irregularities on the skin. Some patients spend hours in front of the mirror trying to improve their appearance. Acne excoriee is sometimes associated with body dysmorphic disorder (1, 8).

Trichotillomania is an impulse control disorder characterized by repetitive, stereotypical, hair pulling, resulting in alopecia. Since some patients describe ritualistic behaviours and irresistible urges to pull their hair, several authors consider that this affliction should be included in the spectrum of OCD. It has a prevalence of 0.5- 3.5% and it is more frequent in females. It has an average age of onset of 10-13 years. It is seven times more frequent in children than in adults and when it occurs in adults it is associated with a poorer prognosis (1, 10, 11). Patients have an increasing tension before pulling their hair and a feeling of gratification or relief while pulling their

hair. They are conscious that they produce their lesions. This activity can be time consuming and can interfere with the daily activities or work. Patients try to disguise the sequels and often isolate themselves from other people (1, 2). Clinically, it usually presents with non-scarring alopecia, but scarring alopecia can also occur after repetitive episodes. The hairs on the alopecic plaque have different



Figure 1



Figure 2

lengths, usually short, with blunt ends and small black points at the scalp. The alopecic plaque has an unusual shape and can vary in dimensions from very small to extensive lesions, affecting the whole scalp. The rest of the hair has normal density and the pull test is negative. Rarely patients may pull the hair from their eyelashes, eyebrows, torso or pubic hair. The histopathological examination is not



Fig. 3



Fig. 4

mandatory but when it is performed it shows hairs in all growth phases but mostly in catagen phase, traumatized hair bulbs, melanin pigment casts, minimal inflammation and perifollicular haemorrhage. The hairs resulted may be licked or even eaten- trichophagia- which can lead to trichobezoar (1, 2, 12). It can be associated with obsessive compulsive disorder, anxiety or depression (1). It must be differentiated from alopecia areata and other causes of scarring and nonscarring alopecia. It should also be differentiated from OCD. While in OCD the hair is pulled because of obsessive thoughts and the act itself is an unpleasant compulsion, in trichotillomania patients have a feeling of gratification after pulling their hair (11, 12). Trichotemnomania, a compulsive habit of cutting or shaving the hair, is a rare disorder

but should also be excluded (8). Onychotillomania is a rare condition determined by neurotic picking or manicuring at a nail, resulting in permanent damage. It includes onychophagia, nail picking, hangnails, finger sucking and habit tic deformity. It is an impulse control disorder and has been associated with depression, OCD, delusions of parasitosis, mental illness or hypochondrial delusions, but also with genetic conditions in which the response to pain is reduced, such as Smith-Magenis Syndrome and

Lesch-Nyan disease. Patients use scissors, knives, razorblades or even bite the proximal part of the nail plate. It can affect the fingernails and the toenails. The damaged nails are prone to get fungal, bacterial and viral infections, thus making the diagnosis difficult, especially in patients who do not admit picking on their nails (13, 14).

Onychophagia or chronic nail biting is a compulsive disorder which occurs mostly during childhood but can persist into adulthood. It is quite frequent and it only becomes pathological when it leads to aesthetic damage or social avoidance (8, 13). Several reasons have been described for nail biting. Some patients feel stressed, excited or increasing tension before biting their nails, while other patients bite their nails when they are bored or in an attempt to get rid of the irregularities of the nails or the cuticles. Pacan et al showed in a study performed in 2014 on 339 patients that men bite their nails deliberately while in women this action is unconscious (13). Onychophagia has also been associated with OCD and anxiety (8, 13).

Pseudo-knuckle pads are cutaneous lesions determined by chewing, rubbing, massaging the skin overlaying the extensor surfaces of the fingers. They are more frequent in males and usually affect children. However they have also been described in adults, as an occupational disorder. When it occurs in children it can be associated with obsessive compulsive disorder. Knuckle pads, which are idiopathic benign cutaneous lesions and are not determined by trauma, should be excluded (8, 15).

Morsicatio buccarum is a frequent but underdiagnosed disorder determined by the compulsive habit of biting the lip, tongue or cheek, leading to hyperkeratosis. The patients are aware that they provoke their lesions. The affliction disappears when the patients stop their behaviour. The lesions can be white and elevated or ulcerated. They have been associated with OCD (8, 16).

The management of the patients suffering from OCD is complex and it involves medication, behavioural therapies, counselling, hypnosis and supportive groups. Selective serotonin reuptake inhibitors like fluoxetine, escitalopram, paroxetine and sertraline are the first line treatment for OCD. Clomipramine has also been used with some good results. (1, 2, 17). In patients who also present skin

lesions, oral antihistamines like doxepin and hydroxyzine may be used to alleviate the pruritus. Cool compresses and topical antibiotics are sometimes needed. Patients with prurigonodularis might need corticosteroids (1, 12).

Conclusions

Approximately one third of the patients addressing dermatology departments throughout the world have psychiatric comorbidities. Whether they cause the dermatological disorder or they are determined by it, psychiatric comorbidities are a real burden for the patients and often impede a favourable evolution of the disease. A close collaboration between the dermatologist and the psychiatrist is therefore mandatory.

Disclosure

No authors involved in the production of this article have any commercial associations that might pose or create a conflict of interest with information presented herein.

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