Simultaneous presentation of trichotillomania and neurotic excoriation in a schizophrenic patient: case report

Apresentação simultânea de tricotilomania e escoriação neurótica em paciente esquizofrênico: relato de caso

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ABSTRACT
The present report aims to describe the case of a patient with excoriation disorder and trichotillomania comorbid with schizophrenia. This is a patient diagnosed with schizophrenia more than 30 years ago and who had a stabilized psychic condition. In one of his periodic evaluations, he began to demonstrate compulsive acts of picking at the skin and from then onwards, lesions appeared on the face, upper limbs and scalp with progressive involvement of other regions. The approach of these mental disorders represented a challenge, because despite a growing number of studies, clinical and therapeutic questions remain open.

Keywords: dermatillomania, trichotillomania, obsessive-compulsive disorder.

RESUMO
O presente relatório visa descrever o caso de um paciente com distúrbio de escoriação e comorbidade trichotillomania com esquizofrenia. Trata-se de um paciente diagnosticado com esquizofrenia há mais de 30 anos e que apresentava uma condição psíquica estabilizada. Numa das suas avaliações periódicas, começou a demonstrar actos compulsivos de picada na pele e, a partir daí, surgiram lesões na face, membros superiores e couro cabeludo com envolvimento progressivo de outras regiões. A abordagem destas perturbações mentais representou um desafio, pois apesar de um número crescente de estudos, as questões clínicas e terapêuticas permanecem em aberto.

Palavras-chave: dermatillomania, trichotillomania, transtorno obsessivo-compulsivo.

1 BACKGROUND

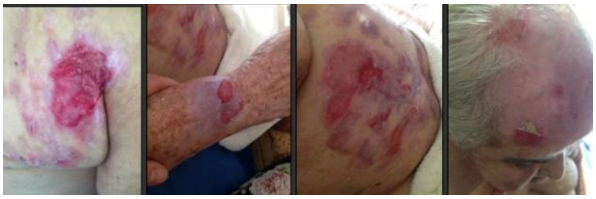
Neurotic excoriation, also called excoriation disorder, dermatillomania and skin disorder, consists of self-mutilation through pinching, poking, puncture and recurrent bites on the skin, causing dermatological lesions and, therefore, infections, scars, social and physical damage, with a prevalence of 1.4% to 5.4%, being more common in females (Machado; Ribeiro; Coginotti). The excoriation disorder, according to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is on the list of obsessive and compulsive behaviors (DSMV). The disorder is subdivided into: para artefacta dermatitis - in which the individual recognizes the authorship of the lesions, being partially aware of the behavior - and

artefacta dermatitis - when the patient is unaware of having caused the excoriation, being as in a dissociative condition (Coginotti). Also associated with obsessive-compulsive disorders, trichotillomania is a psychodermatological disorder characterized by the impulse to pull one's own hair, resulting in noticeable hair loss, consisting of a differential diagnosis of the most common alopecias, such as alopecia areata. The prevalence varies from 0.6% to 3%, more common in women (PINTO). Trichotillomania and excoriation disorder are related to each other and to other major mental disorders, such as depression and anxiety, mood disorder, and drug abuse, smoking, and alcoholism (Machado; Ribeiro; Coginotti). Repetitive acts represent a symbolic manifestation of psychic contents together with non-formalized verbal expressions or a reaction to a psychophysiological imbalance, functioning as a channel of stress energy generated by tensions and adversities or by the need to receive emotional support, consisting of a search for relief. (Coginotti).

2 OBJECTIVE

This article aims to report the presence of trichotillomania and neurotic excoriation disorder in an elderly schizophrenic patient with endocrine-metabolic and cardiovascular comorbidities.

case report



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Patient, female, 83 years old, widow, retired, hypertensive, insulin-dependent diabetic with complications, with Chronic Kidney Disease (CKD) and Gastroesophageal Reflux Disease (GERD), bedridden and subject to basic care for her daughter, had been diagnosed with schizophrenia at 43 years. At 79, he began to perform repeated acts of scratching/pinching, causing multiple excoriations on the skin. The first episode of excoriation was in the maxillary and frontal regions. Subsequently, it began to attack the scalp, ulterior to other regions of the face, upper limbs,abdominal, nipple, infrascapular and groin. The method used for self-mutilation has always been rubbing the skin or scalp. These acts were committed compulsively and consciously. The patient even stated, at the beginning of the episodes, that the lesions were due to a skin cancer “left to her” by her deceased husband. But, with the progression of the acts, he only mentioned that he couldn't stop hurting himself because his skin was constantly itching.

He also presented social isolation, affective blunting, avoidant and suspicious behavior most of the time, hypobulia and hypopragmatism. Most episodes were preceded by the absence, even for a few hours, of the daughter who was caring for the patient or when the house was more agitated. On admission to Hospital Dia do Idoso, in January 2017, the patient was using quetiapine 25mg every 12 hours, Risperidone 2mg (0.5CP + 0 + 1CP) and Donaren 50mg/night. It was decided to maintain Quetiapine, decrease the dose of Risperidone and add Venlafaxine Hydrochloride 75mg due to affective blunting, anhedonia and absence of episodes of delusions or hallucinations in the last 10 days. Subsequently, there was an exacerbation of psychotic symptoms and worsening of self-mutilation mania.

The quetiapine dosage was changed (100mg + 0 + 25mg), carbamazepine 200mg/night was introduced and the use of Risperidone and Donaren was discontinued. This culminated in an improvement in the positive symptoms (hallucinatory symptoms and delusions) of schizophrenia, but it followed with worsening of the negative symptoms (anhedonia and incommunicability) and in the compulsive condition. Therefore, Depakote ER 500mg, Sulpan, Quetiapine (100mg + 0 + 200mg), Quetiapine 25mg if major agitation and Quetiapine XR 50mg after breakfast were prescribed. With this therapeutic regimen, a significant improvement in positive and negative symptoms was observed. However, there was no response to the symptoms of dermatillomania, and mechanical restraint of the patient's hands was suggested to control the lesions that could evolve with an infectious process. The patient continues to be monitored with periodic consultations and under home care. In addition, from the beginning of the follow-up, guidelines on dressing technique with Silver Sulfadiazine were given to the daughter who irreproachably follows the patient, protecting her from infectious complications.

3 DISCUSSION

Neurotic excoriation is a condition that is often associated with psychosocial dysfunction. The repetitive act becomes pathological when it affects large areas of skin, causing skin lesions, which can promote dysfunctional behaviors and social damage by causing embarrassment, fear and anxiety in the patient. (MACHADO., CARVALHO, 2017). On the other hand, trichotillomania can cause irreversible damage to hair growth and quality. It is also associated with suffering, social and professional impairment, and is often accompanied by other mental disorders, most commonly major depressive disorder and excoriation disorder. (MSD Manual., 2018). The patient in the case reported has a compulsion to excoriate herself, and the persistent behavior of pulling out her own hair, characterizing the concomitant presentation of trichotillomania. In view of this, the clinical history of the diagnosis of

schizophrenia, a mental and chronic disease, which may present as symptoms of self-mutilation, compulsive behavior and repetitive movements, thus predisposes the simultaneous development of the act of excoriation and trichotillomania, considering that both clinical pictures are associated with psychopathological dysfunctions. The diagnosis of neurotic excoriation is clinical and must follow the criteria evaluated by the DSM-5: (1) visible skin lesions; (2) attempt to reduce episodes of self-injurious actions; (3) there are no clinical conditions that justify it; (4) the act causes significant suffering. Trichotillomania must also meet the main diagnostic criteria: (1) hair removal; (2) repeated attempt to stop hair pulling; (3) show commitment to carrying out activities. The patient mentioned presented the evaluated clinical criteria, concomitant with avoidant behavior, social isolation and affective blunting. There are no clear pharmacological therapeutic guidelines available. Treatment depends on the patient's clinical condition regarding the comorbidities and triggering factors of the disorder. Regarding the pharmacological therapy of trichotillomania, the use of SSRIs or clomipramine, a tricyclic antidepressant with potent serotonergic effects, is indicated for patients who have coexisting disorders such as depression and anxiety. N-acetylcysteine, a partial glutamatergic agonist, is also effective in patients with dermatillomania. In neurotic excoriation, the same treatment methods can be used, despite studies showing more efficacy in controlling trichotillomania. (GRANT JE; ODLAUG BL; KIM, SW., 2009). Cognitive-behavioral treatment is also observed, which seeks to alleviate the specific symptoms of trichotillomania and excoriation disorder. It has become a psychotherapy of choice associated or not with drug treatment results. It presents awareness as the main method of treatment to identify triggers that lead the patient to repetitive acts of pulling out the hair, as well as pinching the skin. In addition, stimulus control is oriented towards modifying situations that lead to these actions, in order to avoid triggers. Finally, to try to reverse the habit, there is the training of the alternative or competitive response, that is, the patient replaces this act with other behaviors. (TOLEDO E.L., 2014). In the case of the patient above, the use of antidepressant and antipsychotic drugs, such as Quetiapine, Risperidone and Donaren, can be seen, which were used to try to reduce affective blunting, anhedonia and episodes of delusions or hallucinations. However, he observed the non-restraint of trichotillomania and neurotic excoriation, so he opted for cognitive-behavioral treatment, such as restraining the hands so that there is no infectious process at the injured site, along with guidelines for reversing habits.

4 CONCLUSION

For years, self-injury processes were more widely studied in the dermatological area, as they were classified as psychodermatoses. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) of the American Psychiatric Association (APA, 2002) excoriation disorder and trichotillomania were not formally recognized, being only cited within the chapter of impulse control disorder without another specification, and that do not meet the criteria presented in the manual for any other impulse control disorder. The DSM-5 (APA, 2014) included the diagnosis of Excoriation Disorder (skin picking) and Trichotillomania (hair pulling disorder) as part of the Obsessive Compulsive Disorder and other related disorders chapter describing the diagnostic criteria. Among the particularities of the disorder described in the DSM-V, there is the fact that the harmful act does not normally happen in the presence of other people, which justifies the intensification of the condition in the periods when the patient's daughter was absent. In addition to the fact that it is usually returned to pinching an area of the skin considered to be of bad appearance or presenting a stain justifying the patient's concern about skin cancer. Both trichotillomania and neurotic excoriation can cause serious and irreversible damage to the skin and, in extreme cases, can even lead to hospitalization. Early identification and establishment of the diagnosis, plus non-pharmacological treatment such as cognitive behavioral therapy and habit reversal exercises, can prevent further complications and permanent damage and disfigurement. As for pharmacological treatment, fluoxetine is still the most used, although there is a need for further studies on the effectiveness of this and other drugs.

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