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ÚLCERA DA ASA DO NARIZ - UM CASO INVULGAR

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RESUMO – A dermite *artefacta* é uma doença caracterizada por lesões cutâneas auto-induzidas, resultado ou manifestação de perturbações psiquiátricas. As manifestações clínicas são variáveis e compreendem erosões superficiais ou úlceras profundas em áreas acessíveis ao alcance das mãos. Pela sua raridade e polimorfismo das lesões, a dermatite *artefacta* é frequentemente um desafio para os médicos. Descreve-se o caso de uma mulher de 62 anos com úlcera do nariz com três anos de evolução causada por manipulação digital.
O reconhecimento precoce da dermatite *artefacta* é difícil mas permite evitar tratamentos desnecessários. É necessária uma abordagem pluridisciplinar desta entidade de modo a obter os melhores resultados.

PALAVRAS-CHAVE – Dermite *artefacta*; Úlcera; Depressão.

A NONHEALING ULCER ON THE NOSE - A CASE REPORT

ABSTRACT – *Dermatitis artefacta is a disease characterized by self-inflicted skin lesions as the result or manifestation of psychiatric disorders or specific stress situations.*
Clinical manifestations range from superficial erosions to deep wounds. Because of its rarity and the polymorphism of the lesions, dermatitis artefacta is often a challenge for the clinicians. This report presents the case of a 62-year-old woman who had an ulcer of the nose lasting for three years caused by digital manipulation. Early recognition of dermatitis artefacta is difficult but avoids unnecessary treatments. A multidisciplinary approach to this entity is necessary to obtain the best results.

KEY-WORDS – *Dermatitis; Ulcer; Nose diseases; Depression.*

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INTRODUCTION

Dermatitis *artefacta* is a rare artifactual skin disease[1-3] with an etiopathology that is not completely understood[1,3] and the prevalence may be higher than perceived[1,2]. It is caused entirely by the actions of the fully aware patient on the skin, hair, nails or mucosa, with no rational motive for this behavior[4]. The condition is more common in women[1-3]. The lesions are usually bilaterally symmetrical, within easy reach of the dominant hand, and may have bizarre shapes with sharp geometrical borders[2,4]. Patients may induce lesions by rubbing, scratching, picking, cutting, punching, sucking, biting, injecting substances, applying dyes, heat or caustics or using some instruments[1-4]. Reported associated conditions include obsessive-compulsive disorder, borderline personality disorder, depression and psychosis[1-5].

CASE REPORT

A sixty six-year-old caucasian woman was referred to our Department of Dermatology because of deep ulcerative lesion involving the left nasal ala associated to intense pruritus, without hypoesthesia, lasting for 2 years. The patient appeared remarkably unconcerned and only answered with difficulties to the questions of the anamnesis, explaining poorly her symptoms. During the first consultation, she related that the lesion has begun after the use of a nasal canula during a hospitalization for laterobulbar stroke 2 years before, and that failed to heal and gradually expanded. Her past medical history was significant for renal polycystic disease with right nephrectomy, leading to terminal renal insufficiency. Her father and her two sisters died of renal polycystic disease.

At presentation, the patient was noted to be missing approximately half of the left nasal ala. In its stead, there was erosion surrounded by hemorrhagic crusting and a margin of mild erythema and edema. The erosion was indurated but non tender. The nares appeared to have some mucosal inflammation (Fig. 1). In order to exclude a cutaneous tumor and others dermatological disorders, a punch biopsy was performed and the patient was treated with fusidic acid cream. The histopathological examination showed an unspecific ulceration with dense inflammatory infiltrate and did not define neither malignant-cellular proliferation nor granulomatous infiltration (Fig. 2). A biopsy of the lesion revealed reactive hyperplasia of the dermis with neither malignant-cellular proliferation nor granulomatous infiltration. The ulcer continued to progress. Intralesional infiltration of corticosteroids was tried to diminish the itch and the inflammation with slight and temporary improvement. Because of the progression of the lesion, an incisional biopsy were performed and revealed a dense inflammatory infiltrate, consistent with unspecific ulceration. The patient's mood was even lower leading to be

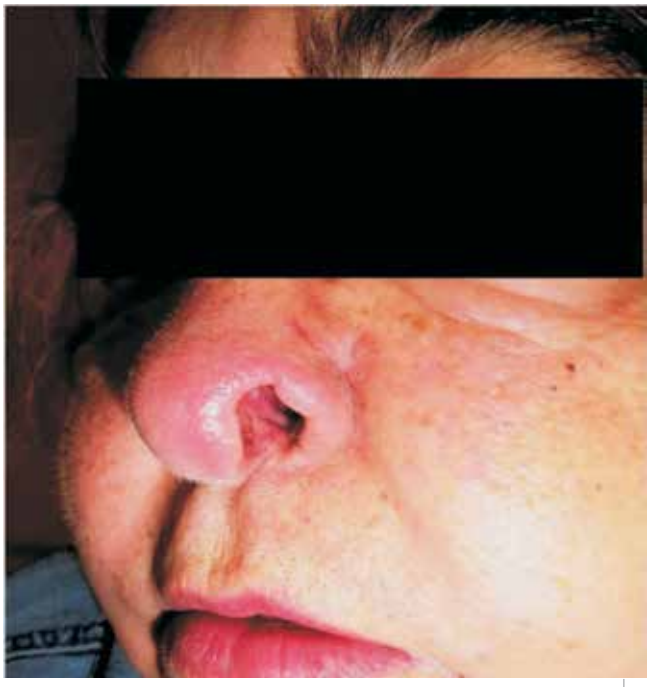

Fig. 1 - Defect of the left nasal ala with slight inflammation.

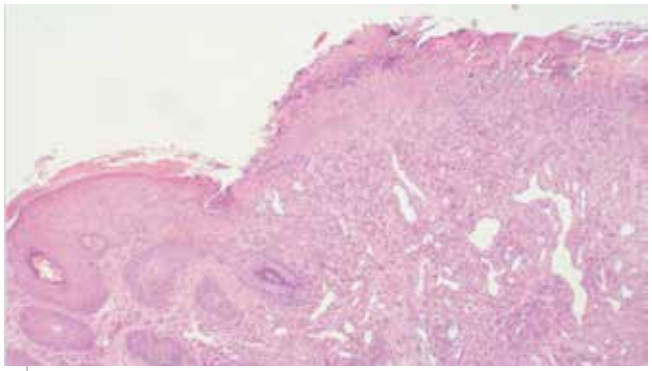

Fig 2 - Unspecific ulceration with dense inflammatory infiltrate on histopathological examination (H&E, 100x).

unable to be in public. After exclusion of others dermatological diseases, the suspicion of dermatitis *artefacta* was considered. When confronted in a non-accusational manner, the patient admitted scratching the nose but insisted that she did it because of the itch caused by the lesion. She mentioned that the whole problem began with the trauma of the nasal canula that causes intensive itch. She was treated with hydroxysine (25mg 2-3 times per day) and amitryptiline (25mg once a day). A local dressing was tried in order to disrupt the cycle of digital trauma with no significant results.

After several consultations, the approach that a psychiatrist would help her to diminish the itch was done and then posteriorly, we referred her to a psychiatrist who confirmed the diagnosis of dermatitis *artefacta* and make the diagnosis of a Major Depression with obsessive compulsive symptoms. The psychiatrist added agomelatine (25mg once a day) and suggested the nasal reconstruction for improving the patient's depression. During the follow-up, the patient admitted that she took previously antidepressants that she decided to stop. After several months of treatment with amitriptiline and agomelatine, she still scratched her nose and we obtained no significant results in stopping the progression of the lesion but improvement in the patient's mood were noticed. The patient was demanding for reconstructive surgery of her nasal defect. She went to a consultation of dermatological surgery and the reconstruction was planned.

DISCUSSION

Comorbidity of depression and dermatologic disorders is around 30%[7]. The skin is the most common site for self-damaging behaviors because it is easily accessible and often the lesions are presented in an ostentatious manner[7]. The most common manifestations of self-destructive behavior are manipulations on the arms and legs, especially incisions on the forearms and are rarer in the nasal area[8]. The compulsive nose picking (rhinotillexomania) is a common benign habit in children and adults that may rarely become a serious affliction advancing to significant self-injury[9].

Characteristically, the patient with dermatitis *artefacta* appears remarkably unconcerned in face of lesions that are morphologically bizarre, often geometric in outline, destructive, and reportedly of sudden, mysterious yet fully formed appearance, but are otherwise cooperative, allowing multiple diagnostic procedures or therapeutic measures[1,5,7]. It is extremely difficult to comprehend why individuals intentionally inflict damage on themselves. Indirect diagnostic confirmation may be obtained by lesion healing after wound isolation with occlusive dressings.

Physicians may be hesitant to diagnose dermatitis *artefacta* because they fear that they might be missing organic disease or perhaps because they are unwilling to believe that the patients could be deceiving them[5].

The differential diagnosis of a facial ulceration is broad and includes, besides dermatitis artefacta, trigeminal trophic syndrome that was not suggested in our case due to the absence of paresthesias and/ordysesthesias after trigeminal damage, and others etiologies as neoplastic (basal or squamous cell carcinoma), infective (herpetic reactivation, syphilis, leishmaniasis, mycobacterial infection, leprous trigeminal neuritis, paracoccidioidomycosis, blastomycosis), and inflammatory (Wegener's granulomatosis, pyoderma gangrenosum and sarcoidosis) etiologies were excluded by the biopsy.

Management must be delicate and a strong rapport with the patient is essential[1]. Psychiatric referral should be carefully considered, as the patient may interpret it as rejection and intensify the self-induced cutaneous lesions. Patients should be referred for psychiatric evaluation only after an adequate patient-physician relationship has been established. Initially, direct confrontation with the patient and the diagnosis is discouraged[3,5] as the patient will be in denial and may be lost of follow-up[1,5]. When confronted it has to be done in a non-accusational manner. It is common for these patients to refuse psychiatric referrals[1]. Although long-term studies are rare, the prognosis is considered poor[1,6].

This case illustrates a rare and exuberant cause of ulcer of the nose[3,4]. The establishment of the diagnosis is often a time-consuming and complicated process that

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precedes acceptance of the underlying pathology[1,5]. Thus, recognizing and correctly diagnosing dermatitis *artefacta* is critical to avert unnecessary tests and treatments, allowing for more efficient management and better healing[1,7,9]. This case shows typically the indifference of the patient. It also demonstrates that the strong rapport with the patient was essential in order to adhere to treatment and to begin evaluation with a psychiatrist.

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