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**EDİTÖRE MEKTUP / LETTER TO THE EDITOR**

# Dermatitis artefacta with finger loss

## Parmak kaybı ile sonlanan dermatitis artefakta

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To the Editor,

Dermatitis artefacta (DA) is one of the psychodermatologic diseases. Management of the disease is a challenging issue both for dermatologists, and psychiatrists. It can manifest with various clinical manifestations. DA resembles borderline personality disorder (BPD) because of self-inflictin behaviours1, and schizophrenia due to loss of insight. There fore difficulties are experienced during diagnostic and therapeutic processes. In addition to its resemblance to some mental illnesses, compelling obstacles of daily life can lead to development of self-mutilative behaviours as seen in DA. In this paper a female patient with DA, who developed self-mutilative behaviours after a traumatic event which resulted in amputation of her little finger.

A 22-year-old, unmarried female patient with low-moderate socioeconomic level was living in an urban area of a city with her family. She was the oldest daughter of her family, and had two brothers. She had a moderately successful school performance. She was living in a religious family that is strictly bound to their customs, and traditions. The patient who was consulted with dermatology clinics had not presented to a psychiatry clinic before.

She stated that 2 years ago increasing number of lesions appeared on her left little finger which could not be cured despite treatments applied by many dermatologists. As a result of biopsies, and examinations performed in all medical centers, this condition was not associated with a dermatologic disorder. Two months previously, her physician indicated circulatory disorder of her little finger which necessitated amputation. This operation was performed with the approval of herself, and her family. She said that a new lesion did not develop within postoperative 2 weeks, however afterwards her lesions recurred, and she consulted again to a dermatologist because of fear of losing her remaining fingers. Upon psychiatric evaluation of the patient hospitalized in the dermatology clinic daily control visits were decided upon.

During first interviews, together with the examination of her mental state, her anamnesis, and family history were obtained in detail. She told us that her family knew that she was hospitalized in the dermatology service. However, since her family was living in another city, and because of her father's busy schedule, any family member had not come to accompany her. Her orientation was intact, her self-care was satisfactory. However impulse control of the patient with depression was impaired without any perceptual /thought disorder. MMPI, Rorschach, and TAT tests were performed, and any psychotic finding was not found.

During further interviews she started to sob, and expressed that she wanted to share an issue which she hadn't told to anyone before. With an empathetic approach she was encouraged to share her experiences. She told that she had a sweatheart 3 years ago, and they thought to get married so they lived an extramarital affair. For one year they led a

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sex life, then her lover abandoned her which was an unacceptable situation for her, her family, and her cultural environment. She had not entertained suicidal thoughts, however she feared that her family would kill her if they had learnt. So, she didn't told this event to anyone. The family was invited for an interview, however the patient had never approved this interview, and she had never invited her family for an interview.

During on-going interviews, the patient was encouraged to share her feelings, and thoughts. Gradually her depressive mood improved, and after 3 weeks of periodic interviews new lesions did not appear, and existing ones started to heal, so she was discharged from the dermatology clinic. Since she did not attend control visits after her discharge, we haven't learnt if she shared this traumatic event with her family. We did not ask, and also she didn't ever tell anything about the wounds on her arms.

DA patients present with various skin lesions which can not be explained by any medical condition. Besides DA patients refrain from assuming any responsibility for these skin lesions, and they unconsciously malinger. Ulcers, linear excoriations are defined as the most frequently seen symptoms, as are presented herein, DA may even progress till mutilation of a finger[3] Diagnosis of DA requires extremely attentive dermatologic examination, and detailed psychologic evaluation. In this case presentation, since mutilation of her little finger suggested psychotic processes, psychologic tests were performed.

DA has been evaluated as revival of childhood offenses, inflictions, sexual/physical abuses, and non-verbal help cry .[4] The patient's behaviour which he/she thought to conflict with his/her cultural environment, transformation of this behaviour to a traumatic event, reluctancy to share this experience with anybody which lead to appearance of skin lesions may be seen as non-verbal help cries. Deep solitude, firm superego attitudes, perceiving the family as being a life threat, rather than a life support may explain patient's self-mutilative behaviour leading to amputation of her finger. As seen in this case presentation, even this previously reticent patient's sharing her experiences with someone may be great stride in her treatment.

Patient's severe self- inflicting behaviour may be seen as her attempt to assess, and understand her value. She may perceive living an extramarital sexual affair as being wiped out by the community, and one may thought that by inflicting herself she may try to delineate the boundaries of her lost ego. By re-marking the boundaries of her self-identity, she might prove that she was not indeed wiped out, and she might try to feel her existence

It has been reported that median age of the patients diagnosed as DA is 20, and DA is more frequently seen in women, and people with lower socioeconomic conditions[3]. As is seen in this case report, cultural factors may face us as the most important predisposing factors

Modern treatment methods have become increasingly prevalent, and biological markers have been investigated to diagnose mental diseases easily, and new imaging methods have illuminated the path in front of us. These scientific contributions allow us to make great strides in the field of psychiatry, contrary to other disciplines, the most important treatment armamentarium still seems to be skills of communication, and empathy. Indeed symptoms of the patient regressed without the need for medical treatment

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