Disturbance in the Well-being of a Patient with Acne: Suggestions for Anticipation and Detection

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Sir,
According to surveys, approximately 30–50% of persons between 12 and 20 years of age with acne show psychological responses to their disease, which includes lowered self-esteem, lack of self-confidence, perceived social rejection as well as anxiety and depression (1–6).

We describe here a patient with acne who suffered from a toxic dermatitis after topical application of a wart solution on his acne lesions due to an unrecognized reduction of his well-being.

CASE REPORT

A 14-year-old male teenager affected by acne for 2 years received different topical treatments, including benzoyl peroxide, erythromycin and a cleansing agent from his general practitioner. Nevertheless, the skin condition of the patient failed to improve significantly in the perception of the patient.

On a Friday night, while preparing for a party in front of a magnifying mirror, he noticed new facial acne lesions. According to the patient, feelings of sadness, despair and anxiety – which had been prevalent for several days to a minor degree – were increasing enormously at that moment.

For relief of his complaints, he spontaneously decided to apply a Russian phenol-containing wart remedy, which is recommended for use in adults only. He started with the forehead region, where the solution was painted with an enclosed brush relatively homogeneously. Next he made three strokes of the brush vertically on his right cheek, followed by a flash-like figure on his left cheek. After 5 min, he noticed a burning sensation on the self-treated area and decided to use soap and tap water to remove the solution.

Due to persisting burning sensations as well as skin discolorations, the patient came to our dermatological emergency department the next morning. Dermatological examination revealed an acne vulgaris complicated by a toxic dermatitis (Fig. 1).

Under topical treatment with steroids in conjunction with sun protection, the toxic dermatitis made a full recovery. For his acne lesions, a combination of systemic antibiotics and topical benzoyl peroxide was initiated. The origin of acne, its course and options in treatment were discussed with the patient in detail. A screening instrument for the presence of well-being in the previous 2 weeks (WHO-5) (7) indicated poor well-being and further diagnostic measures by a mental

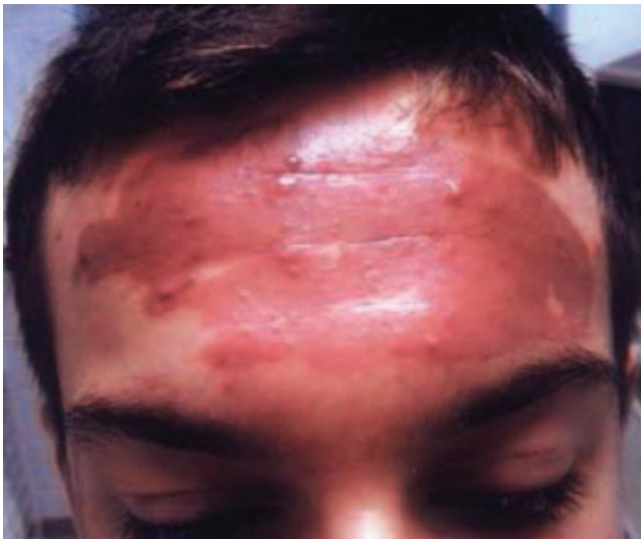

Fig. 1. Acne patient with toxic dermatitis of the face after application of a phenol-containing wart remedy.

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health professional were initiated. The patient was advised to contact the dermatological outpatient department without delay whenever the impression of a severe worsening in his facial skin condition occured.

DISCUSSION

Many different causes may lead to a disturbance of well-being in an acne patient. A response to core developmental changes which affect individuation into adulthood (e.g. body imaging, sexuality, and educational or vocational choices) might be responsible (2, 8).

Interestingly, Gupta and co-workers (9) identified that three out of ten patients (age range 19–34 years) with mild to moderate facial acne suffered from a psychiatric disorder. Furthermore, seven out of ten patients with acne showed a history of a major depressive episode that was exacerbated by an acne-related affection of self-consciousness (9).

As one in seven individuals has a diagnosable neurotic disorder (mainly depression or anxiety) (10) and four in thousand suffer from a functional psychosis (mainly schizophrenia or affective psychosis) (11), it is important for the dermatologist to recognize psychiatric co-morbidity as well as potentially medication-induced symptoms, when managing patients with acne (2). Nevertheless, according to Wessely & Lewis (12), dermatologists tend to underestimate the prevalence of psychiatric disorders. In cases requiring psychiatric intervention, dermatologists recognized less than 40% of cases (12).

Sometimes, the use of a screening instrument like the WHO-5 (7) or GHQ-12 (13) may offer an advantage in the detection of a diminished well-being in a busy dermatological office. The WHO-5, as a prototype of a favourable screening instrument, is brief, highly sensitive and acceptable to patients (14). It can be completed rapidly and without difficulty by patients over a wide range of age and intellectual ability (14). Furthermore, the time needed for reviewing of the instrument is kept to a minimum (14).

Nevertheless, self-reporting scales like the WHO-5 have a number of limitations as compared with semi-structured psychiatric interviews, which can often provide more information about current diagnoses and past psychiatric history (15).

Finally, it has to be stated that a positive screen (e.g. with the WHO-5) does not necessarily represent a diagnosis of a psychiatric disorder. Therefore it is recommended that dermatologists seek the advice of a mental health professional immediately after encountering a patient with acne scored positively for a poor well-being.

REFERENCES

1. Aktan S, Ozmen E, Sanli B. Anxiety, depression, and nature of acne vulgaris in adolescents. Int J Dermatol 2000; 39: 354–357.
2. Cotterill JA, Cunliffe WJ. Suicide in dermatological patients. Br J Dermatol 1997; 137: 246–250.
3. Girman CJ, Hartmaier S, Thiboutot D, Johnson J, Barber B, De Muro-Mereon C, et al. Evaluating health-related quality of life in patients with facial acne: development of a self-administered questionnaire for clinical trials. Qual Life Res 1996; 5: 481–490.
4. Gupta MA, Gupta AK. Depression and suicidal ideation in dermatology patients with acne, alopecia areata, atopic dermatitis and psoriasis. Br J Dermatol 1998; 139: 846–850.
5. Richter A. Belastungen und Bewältigungen bei jungen Erwachsenen mit Akne unter besonderer Berücksichtigung des psychosomatischen Behandlungskonzepts. Thesis for psychologist's diploma, University of Regensburg, 1990.
6. Welp K, Gieler U. Acne vulgaris: morphologische, endokrinologische und psychologische Aspekte. Z Hautkr 1990; 65: 1139–1145.
7. World Health Organization, Info package: mastering depression in primary care. Frederiksborg: World Health Organization, Regional Office Europe, Psychiatric Research Unit, 1998.
8. Gupta MA, Gupta AK. The psychological comorbidity in acne. Clin Dermatol 2001; 19: 360–363.
9. Gupta MA, Gupta AK, Schork NJ, Ellis CN, Voorhees JJ. Psychiatric aspects of the treatment of mild to moderate facial acne. Int J Dermatol 1990; 29: 719–721.
10. Charlton J. Trends in suicide death in England and Wales. Population Trends 1992; 69: 10–16.
11. Meltzer H, Gill B, Pettigrew M. A prevalence of psychiatric morbidity among adults aged 16–64 living in private households in Great Britain. OPCS Surveys of Psychiatric Morbidity in Great Britain. Bulletin No. 1. London: HMSO, 1994.
12. Wessely SC, Lewis GH. The classification of psychiatric morbidity in attenders at a dermatology clinic. Br J Psychiatry 1989; 155: 686–691.
13. Goldberg DP. Manual of the general health questionnaire. Windsor: NFER Publishing Company, 1978.
14. Henkel V, Mergl R, Kohnen R, Maier W, Möller H-J, Hegerl U. Identifying depression in primary care: a comparison of different methods in a prospective cohort study. BMJ 2003; 326: 200–201.
15. Ng CH, Tam MM, Celi E, Tate B, Schweitzer I. Prospective study of depressive symptoms and quality of life in acne vulgaris patients treated with isotretinoin compared to antibiotic and topical therapy. Australas J Dermatol 2002; 43: 262–268.