

## Recurrent Deep Ulcers Resembling Rare Cancers as a Form of Factitious Disorder

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Factitious disorders are defined as acts of self-harm that directly or indirectly result in clinically-relevant injury. They are typically performed in secret and without direct intention of suicide (1, 2).

The patient's initial goal is hospital admission and receiving medical treatment to confirm the severity of their state (3).

Current prevalence ranges of factitious disorders is between 0.05 and 2.0%, with women being 4–20-fold more likely to be affected than men (1, 4–8). Contemporary psychodermatology classifies these disorders as: 1) dermatoses of primary psychiatric genesis (emotional/psychiatric disorders); 2) dermatoses with a multifactorial basis, of which the course is subject to psychiatric influences (psychosomatic disease); or 3) secondary psychiatric disorders due to serious or disfiguring dermatoses (somatopsychic disease) (9). Mood swings, anxiety, impulsive behavior and somatization disorders are common among patients with dermatitis artefacta (5, 10–12).

### CASE REPORT

A 60-year old patient was initially admitted to our dermatology department in December 2008 with an ulcer on her glabella. A review of her medical history revealed that she had undergone a hysterectomy and bilateral ovariectomy in 1997.

The first small ulceration (0.5 cm) appeared on the patient's chin in 1999. The lesion was treated by antibiotic without any success and excised after a few months. The histopathological examination excluded cancer. In 2000 a new lesion appeared on a different part of the patient's chin. Malignancy was again excluded. Scintigraphy and microbiological tests for tuberculosis, syphilis and mycotic infections were performed. As the patient had visited India, conducted tests for tropical diseases were negative. By the following year, the lesion had grown to 5 cm in diameter. Skin desmoid with connective tissue infiltration into muscle was suggested as a possible diagnosis after skin biopsy. Radical excision of lesion was performed in 2002. Two further centers excluded malignancy and desmoid.

Between 2002 and 2008, a few additional lesions appeared on different parts of the patient's face – within the postoperative wound, on the right cheek and in the cartilage of the nose. Computer tomography and MRI were performed twice during this time to exclude bone infiltration. The lesions were treated with Dapsone, cyclosporin A and steroids, administered both orally and topically, without any effect. All biopsies were also analyzed at the UICC-Telepathology Clinic in the US, where a histopathologist suggested: glomangiomyoma and spindle cell hemangiioendothelioma. In 2008, the patient qualified again for operative treatment. At this time, she also received a consultation in our Dermatology Department.

On the day of examination a single, deep, triangle-shaped ulcer with a diameter of up to 5 cm was observed in the glabella



Fig. 1. Triangle-shaped ulcer in the glabella area.

area. The bottom of the ulcer was filled with granulation tissue and the wound margins were moderately inflamed. Additionally, two small ulcers near the nose and the right eye were observed (Fig. 1). The patient did not suffer any subjective symptoms such as pain, itching or burning.

The patient was admitted to hospital 14 days after the consultation. By the time of her admission, the triangle-shaped ulcer had almost completely healed. However, a single, tiny, irregular-shaped ulcer was discovered in the middle of her forehead.

Due to the fact that the various histopathological diagnoses did not tally with the clinical features, a diagnosis of dermatitis artefacta was suggested. Histopathological biopsy samples were sent for review to Graz and the Department of Pathomorphology, Medical University of Gdansk. The histopathologists independently confirmed dermatitis artefacta. Notably, both observed traces of wood in the deeper scar tissue.



Fig. 2. Complete healing of the wound after 7 days of treatment.

During hospitalization, the ulcer near the glabella was treated with sterile, barren tightly fitting gauze that did not allow manipulation by the patient. The gauze was replaced daily during the following seven days, after which the wound had completely healed (Fig. 2).

An interview by a psychiatrist identified family relationship problems and subdepression as the main underlying causes of the psycho-dermatologic pathology. Recommended treatment included pharmacotherapy with low-strength neuroleptics and antidepressants, as well as long-term psychotherapy. The patient did not accept our diagnosis, but instead claimed that other somatic factors were the cause of the observed skin changes. She did not attend a follow-up appointment in our outpatient department. Our final diagnosis after our detailed physical and psychological examination of the patient is Munchausen syndrome.

## DISCUSSION

The skin plays a powerful role as an organ of communication and in the process of connection throughout life. Psychiatric patients often deny their psychopathology and seek dermatological care for their severe cutaneous symptoms. It has been estimated that the effective management of at least one third of the patients attending skin department depends, to some extent, upon the recognition of emotional and psychological factors (5, 13–15).

The case described above yielded many diagnostic and treatment failures during the course of several years in various national and foreign centers. Many specialist examinations were performed to exclude deeper infiltration of the observed skin lesions. None of these examinations revealed either bone infiltration or the presence of a brain tumor. Detailed observations, as well as examination of the patient's entire medical history, led us to the correct diagnosis.

It is assumed that the patient's behavior was intended to draw her husband's attention. The suspicion that her condition was severe assured her of the care and sympathy of her family. The patient did not accept our diagnosis, probably due to her psychological instability and the fact that after the diagnosis she lost benefits she had been receiving as a result of her condition.

Patients with factitious disorders are emotionally unstable and problematic in consultations. It is difficult to formulate guidelines for managing patients with diagnoses of this kind. In our opinion, one possible form of management would involve creating a trusting relationship, as well as a social environment, and providing support that the patient considers to be helpful and not a threat to his/her self-esteem. There is no right time to talk to a patient about his/her diagnosis. Generally, speaking about self-harming too soon can be as unhelpful

as avoiding the topic for too long. Everything depends on the current pressure to act. No accusations of guilt or belittling should occur in any case (1).

In dermatological practice, special attention has to be paid to patients with long-running illnesses and long-term lack of a proper diagnosis. The fact that such patients often do not provide a complete medical history and are treated by many doctors can make the final diagnosis very difficult. In suspected cases of factitious disorder it is always important to cooperate with psychologists and psychiatrists in order to identify the origins of the observed behavior.

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