

## SHORT COMMUNICATION

### Onychotillomania in the Course of Depression: A Case Report

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Onychotillomania is a form of self-induced damage of nails which results from recurrent picking and manicuring (using different tools, e.g. scissors or toothpicks) of fingernails and/or toenails causing visual shortening and/or distraction of nails (1–3). Onychotillomania should be distinguished from onychophagia which represents another form of self-induced damage of nails caused by nail-biting. The knowledge about onychotillomania is still only based on few case reports. Coexistence of onychotillomania with depression or delusional disorder has been already reported in the past (2, 4, 5). In such cases onychotillomania was described as a compulsion or a behaviour motivated by delusions (2, 4, 5). On the other hand, onychotillomania was also reported in subjects without any other comorbidity of mental disorders, suggesting that in selected individuals it could also be a sole psychiatric problem (6, 7).

To the best of our knowledge, epidemiological data about onychotillomania are very limited. In our recent study including a group of 339 medical students in Poland we found onychotillomania in 3 participants (2 females and 1 male; prevalence: 0.9%) (8). In both women specific phobia was diagnosed (8). Comparing to onychophagia, onychotillomania occurred about 50 times less frequently. Due to its rarity, onychotillomania has not been studied in respect to comorbidities and treatment. To provide more data on this nail problem, we demonstrate a patient with onychotillomania occurring during depressive episodes.

#### CASE REPORT

A 60-year-old man with the diagnosis of recurrent depressive disorder over the past 6 years was admitted to the psychiatric ward because of depressive symptoms with suicide thoughts. He had experienced 6 depressive episodes within the last 6 years. Depressive episodes had occurred every year, and usually lasted about 4 to 6 months. Previously he had been hospitalised 4 times and successfully treated with antidepressive medications. No alcohol or drug abuse was stated, as well as no family history of mental disorders found. Psychiatric examination confirmed the diagnosis of recurrent depressive disorder with the presence of a moderate depressive episode according to the ICD 10 diagnostic criteria (The ICD-10 Classification of Mental and Behavioural Disorders) (9). He had no psychotic symptoms, delusions or

hallucinations. His initial 17-items Hamilton Depressive Scale total score was rated as 25. Current depressive episode started about 12 weeks prior to the admission to psychiatric ward and was unsuccessfully treated with mianserin 120 mg daily. Anamnesis as well as physical examination did not reveal any other relevant medical condition except of a pronounced damage of fingernails of both hands. Patient admitted the self-induced damage of fingernails due to picking them off. To tear off his fingernails he mostly used his thumbs and the index fingers. Because the patient was right-handed, more severe damage was found on the left hand. In addition, fingernails of the 4<sup>th</sup> and 5<sup>th</sup> digits showed the highest degree of destruction, whereas both thumbnails remained almost completely intact. Onychotillomania was diagnosed based on clinical presentation and anamnesis. The patient described a feeling of tension before or when trying to resist the nail picking behaviour, however, sometimes he also destructed his fingernails without intended thinking about it. He reported anxiety of mild severity without any somatic symptoms occurring from time to time during a day, while he worried about his current situation or the future. Remarkably, he did not relate picking off fingernails to his feelings of anxiety. He was aware of the consequences of such behaviour, but he could not stop it. The patient declared that he was damaging his fingernails during each episode of depression. According to the patient, the more severe depressive symptoms were related to the more intense nail damage. Remarkably, during the periods without depressive episodes he had not damaged his fingernails. The patient stated that he had never been picking off his nails when he had not suffered from depression, even if he had felt anxiety or tension.

A detailed interview revealed also problem of onychophagia in the past. Our patient started biting his fingernails when he was 7 years old and continued this behaviour until the age of 15 years. He usually bit nails while he was bored. He reported that his fingernails became very short and “looked very badly”. Due to serious damage of his fingernails, his parents tried to persuade him to stop such behaviour, e.g. they used to paint his nails with bitter-tasting products, however, without any success. Finally, he stopped nail biting when he started the high school. Up until the symptoms of the first depressive episode at the age of 54 years, he neither bit nails nor destroyed them by picking.

During current hospitalization the treatment with sertraline was introduced, starting from 50 mg daily and increasing the dose to 150 mg daily. At the end of the 4<sup>th</sup> week an improvement of the patient mental state was observed. At the same time he started to spend less time picking his fingernails and fingernail damage decreased. After 6 weeks of treatment depressive symptoms ceased as well as onychotillomania behaviour.

## DISCUSSION

Onychotillomania is a type of psychodermatosis that results from repeated self-inflicted behaviour. Our knowledge about this problem is still based only on few case reports. Since 1937, when Alkiewicz (10), who coined the term “onychotillomania”, described a patient constantly damaging the nails of his little fingers, several case reports have been published. As reported, self-destructions may involve both fingernails and/or toenails. Patients usually damaged their nails using various tools, such as scissors, knife, razor blade, toothpick, metal file. In our case report, the patient used his own hands, namely fingernails of thumbs and indexes.

According to ICD-10 onychotillomania may be classified among the other impulse control disorders not explained by any other mental disorder, which leads to self-destruction of nails. Most available reports limit their content to very basic information and only a few include details about causes of self-inflicted behaviour or underlying mental disorder or psychological problems. Onychotillomania was associated with depressive neurosis, obsessive-compulsive disorder, hypochondrial delusions and delusions of infestations (1–5). Although major depression is considered to be related to onychotillomania, 2 described cases of onychotillomania have been reported in the literature (4, 11). In both patients psychotic symptoms were also recognised, in the first case auditory hallucinations and in the second monosymptomatic delusions of infestations. In our case report, self-destruction of fingernails was connected with a feeling of tension occurring during depressive episodes without psychotic symptoms. During remission of his depression our patient also stopped fingernail picking. The repeated behaviour that caused the fingernail shortening with concurrent tension before or while trying to resist nail picking was a variant of a compulsion. However, obsessive compulsion disorder was not diagnosed, as such compulsive behaviour was considered as a symptom of depression.

In all previously described reports patients with onychotillomania were referred to dermatologists. Inte-

restingly, the above-described patient did not seek any help from dermatologist. This could be explained by the fact that while suffering from depressive symptoms, he did not consider his abnormal fingernails as a significant medical problem, even if he confirmed feeling of pain and discomfort related to injured nailplates. Remarkably, our patient reported that until current admission to psychiatric ward, nobody from medical staff, neither in the out-patient clinic, nor in the psychiatric ward, noticed damage of his fingernails as well as he was never asked about his self-destruction behaviour.

The published case reports of onychotillomania confirm that thorough examination including the mental state examination is essential for the comprehensive assessment of the patient's problems and allow to recognise underlying mental disorder, often misdiagnosed previously. Likewise, in patients with diagnosis of mental disorders comprehensive examination enables identification of not only serious medical conditions but also co-morbid psychodermatological problem (such as nail damage, skin signs of scratching, picking etc) that may cause pain or discomfort. Sometimes, as in our case, the patient focuses on certain medical complaints while not reporting other. Thus, these symptoms or disorders may be easily overlooked by clinicians.

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## REFERENCES

- Selvaag E, Thomsen K. Onychotillomania. *Eur J Dermatol* 2003; 13: 48.
- Inglese M, Haley HR, Elewski BE. Onychotillomania: 2 case reports. *Cutis* 2004; 73: 171–174.
- Pacan P, Grzesiak M, Szepletowski J. Onychophagia and onychotillomania. *Dermatol Prakt* 2009; 4: 9–11.
- Lin YC, Lin YC. Onychotillomania, major depressive disorder and suicide. *Clin Exp Dermatol* 2006; 31: 588–602.
- Hamann K. Onychotillomania treated with pimozide (Orap). *Acta Derm Venereol* 1982; 62: 364–366.
- Reese JM, Hudacek KD, Rubin AI. Onychotillomania: clinicopathologic correlations. *J Cutan Pathol* 2013; 40: 419–423.
- Colver GB. Onychotillomania. *Br J Dermatology* 1987; 117: 397–398.
- Pacan P, Grzesiak M, Reich A, Kantorska-Janiec M, Szepletowski JC. Onychophagia and onychotillomania: prevalence, clinical picture and comorbidities. *Acta Derm Venereol* 2014; 94: 67–71.
- World Health Organization. *The ICD-10: Classification of Mental and Behavioural Disorders: Clinical Description and Diagnostic Guidelines* 1992.
- Alkiewicz J. Uber onychotillomania. *Dermatol Wochenschr* 1934; 98: 519–521.
- Sait MA, Reddy BSN, Garg BR. Onychotillomania. *Dermatologica* 1985; 171: 200–202.