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CASE REPORT

Health providers induced iatrogenic delusions of infestation

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Abstract: Patients that suffer from factitial dermatosis mutilate their skin, often lacking any consciousness of self-injury, attributing the resulting lesions to spontaneous development. The case hereby described shows how the health providers' interventions led a patient from a baseline undiagnosed factitious disorder to frank delusions of infestation with *Mycobacterium Kansasii*, and a relentless search for antibiotic treatments. We highlight the need for educating health practitioners on the characteristics of psycho-cutaneous disorders.

Keywords: delusions of parasitosis, delusions of infestation, factitious dermatosis, psychodermatology, dermatology

A 44-year-old female presented to our clinic with numerous painful excoriations and ulcers covering approximately 30 percent of her face, including the partial removal of nasal cartilage which was exposed. She stated that her disease began two years earlier during a period of very significant distress caused by family illness in addition to a contentious divorce. The patient explained that the skin ulcers appeared spontaneously, without her touching them. At that time, she was seen by numerous health providers who performed a total of 4 biopsies and 12 swab cultures; one of these swabs grew *Mycobacterium Kansasii*, which led to the diagnosis of atypical mycobacterial skin infection, treated with rifampin, ethambutol and isoniazid for 16 months, and the latter was replaced by minocycline due to hepatic dysfunction. The patient believed that her skin lesions were not cured because she did not receive the full 18 months of treatment that she read in the Internet was the recommended time. Furthermore, she admitted that after receiving the diagnosis of mycobacterial infection, she then started picking on the lesions in order to remove infected tissue. The patient denied recreational drug use. During her visit, we tried to approach the issue of her emotional distress, but she refused to address this, insisting that she only suffered from a confirmed diagnosis of infection. When one of us in the room (AS) introduced herself as a psychiatrist, the patient became agitated and demanded that she leave, arguing that she had no psychological problems.

With a working diagnosis of factitial and later delusional dermatosis we decided to postpone any psychiatric approach due to her lack of insight, and proceeded to treat her with twice weekly visits to our clinic during which we covered the eroded lesions with silver hydrofiber and hydrocolloid dressings (Aquacel and DuoDerm, Convatec, Greensboro,NC) to prevent her from manipulating them. She was also prescribed 600 mg gabapentin daily. During the following 3 weeks of this regimen,

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she improved markedly, with significant healing of erosions and ulcers; after which she was lost to follow-up, and refused to answer our telephone calls.

Two years later, the patient tried to be seen by an infectious disease specialist in Massachusetts, but her medical insurance required that first she be seen in our institution. She returned to our clinic, and we complied with her demands not to be seen by the previous attending physicians. During this visit with a new dermatologist, the skin involvement extended beyond her face to her scalp, with significant ulcers and resulting cicatricial alopecia covering two thirds of her scalp; yet another biopsy was obtained, which was reported as traumatized skin. She volunteered that during the intervening two years she had been treated at another medical center with an additional 18 months of the same systemic antimycobacterial regimen with the addition of oxycodone. The patient was again lost to follow up. During each of the visits we obtained photographs which are not included due to lack of patient's consent.

Discussion

Self-injurious (factitial or skin picking) skin disease is a frequent disorder seen in the dermatology outpatient clinic, with a reported incidence in the general population of up to 5.4%, presenting within a spectrum of complete conscience to the lack of any insight or awareness.[3,4] This is classified in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as obsessive-compulsive disorder (OCD), characterized by an uncontrollable persistent pattern of picking that progresses to the point of tissue damage and impairs the ability to function normally.[3] Furthermore, many of these patients lack insight into their self-mutilating behavior and demand intense medical workup to identify the cause, which they attribute mostly to infectious or systemic etiologies. The absence of awareness of the nature of their disease results invariably in a refusal to accept referrals to mental health providers; indeed, it is very rare for psychiatrists to encounter such patients.[1] Excluding those who are induced by material (economic) gain, self-injurious patients may be unable or unwilling to integrate the dissociated action of self-injury; dissociative defenses are often present in factitious disorder with or without borderline personality disorder.[2] Patients suffering from unconscious skin picking disorder have no insight into their self-aggression act, and will either state that the lesions appear spontaneously, attribute them to exogenous factors, or present a rather vague description in what has been termed "hollow history".[2] Our patient initially found the ulcers to appear spontaneously without intervening self-injurious behavior, although she did admit that once she was convinced that she had a mycobacterial infection, she started to pick on the ulcers in order to "remove" the infected tissue. She converted from a case of typical unconscious factitious disorder to delusions of infestation[4] albeit encouraged by her treating health practitioners.

There is limited knowledge regarding the etiology of the disorder, including biological, behavioral, psychological, and environmental factors. Most importantly, the presence of significant emotional stressors commonly triggers this condition. Unfortunately, physicians in general lack the training and knowledge to identify this illness, and frequently find it hard to believe that a patient will actively induce the presented degree of disfigurement.[5] In an attempt to find a causal agent, health providers not only validate the patients' perception of the disease, but may in some instances induce another disorder that can become even more difficult to treat, such as delusions of infestation, as seen in our patient.[6]

This case highlights to what degree the lack of knowledge and coordination of care among medical providers can sustain or exacerbate self-mutilating disorders, ultimately leading to low quality of care, potential harm to the patient, as well as increased healthcare costs. In our patient, her disease state was validated by her treating physicians by performing numerous biopsies and cultures and repeatedly treating her with antibiotics for a presumptive infection with *M. Kansasii*, despite the lack of resemblance of her skin lesions to those seen with this rare mycobacterial infection.[7,8] Although our patient admitted to picking on the skin as an attempt to remove infected tissue, she rebuffed any role in the initial production of the lesions. She did not have the conviction that she was infected until her treating health providers diagnosed her with a mycobacteriosis. Her vague description of the sudden onset of her skin lesions is consistent with a dissociated state, in which she lacked cognizance of inducing the lesions herself. Even an accurate diagnosis did not lead to appropriate treatment, since she stopped coming to our clinic soon after objective and subjective improvement. This suggests that self-injurious behavior served her the function of being taken care of during a time of multiple psychosocial stressors and allowed her to engage with providers at a "somatic level", assuming a "sick" role that elicited sympathy and concern from those surrounding her.

Ethics and patient consent

Institutional approval was not required for this case report. As the patient has been lost to follow up, patient consent for publication of this case was not possible. The details have been sufficiently anonymized not to cause harm to the patient.

Disclosure

The authors report no conflicts of interest in this work.

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