Psychocutaneous disease

Clinical perspectives

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Learning objectives
After completing this learning activity, participants should be able to assess the nomenclature and classification of psychocutaneous disease; describe common psychocutaneous diseases/recognize the associated psychiatric/psychosocial comorbidities; and identify appropriate management plans for patients with these diseases.

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Psychocutaneous disease, defined in this review as primary psychiatric disease with skin manifestations, is commonly encountered in dermatology. Dermatologists can play an important role in the management of psychocutaneous disease because patients visit dermatology for treatment of their skin problems but often refuse psychiatric intervention. This review describes common psychocutaneous syndromes, including delusional, factitious, obsessive-compulsive and related, and eating disorders, as well as psychogenic pruritus, cutaneous sensory (pain) syndromes, posttraumatic stress disorder, and sleep-wake disorders. The updated classification of these disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, *5th edition* is included. Strategies for management are reviewed. (J Am Acad Dermatol 2017;76:779-91.)

Key words: antidepressant; antipsychotic; cognitive-behavioral therapy; drug; pruritus; management; psychotherapy; psychocutaneous.

Psychocutaneous disease, defined in this review as primary psychiatric disease with skin manifestations, is frequently encountered in dermatology, with an estimated 30% prevalence of psychiatric comorbidity in the outpatient dermatology setting.[1] Patients with psychocutaneous disease routinely refuse mental health resources, leaving the burden of care upon the dermatologist. Nevertheless, in a recent survey of dermatologists, only 18% reported a clear understanding of psychodermatology, and only 42% were very comfortable in diagnosing and treating psychocutaneous disorders.[2] In this article, we describe

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Abbreviations used:

AN:	anorexia nervosa
BED:	binge eating disorder
BFRBD:	body-focused repetitive behavior disorder
BDD:	body dysmorphic disorder
BN:	bulimia nervosa
CBT:	cognitive behavioral therapy
DA:	dermatitis artefacta
DI:	delusional infestation
DSM-5:	*Diagnostic and Statistical Manual of Mental Disorders 5th edition*
ED:	eating disorder
HRT:	habit reversal training
OCD:	obsessive-compulsive disorder
OCRD:	obsessive-compulsive and related disorder
ORS:	olfactory reference syndrome
RCT:	randomized controlled trial
SPD:	skin picking disorder
SSRI:	selective serotonin reuptake inhibitors

common psychocutaneous conditions and their categorization in *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5).[3] Appropriate management plans for patients with these diseases are included.

DELUSIONAL INFESTATION

Key points

- **Delusional infestation is the most common monosymptomatic, hypochondriacal psychosis in dermatology**
- **Antipsychotic medications have a high response rate**

In delusional infestation (DI; also known as delusions of parasitosis), patients have a fixed, false belief that they are infested with parasites or have foreign objects extruding from their skin.[4] It is an "encapsulated" (monosymptomatic) delusion (ie, the sole delusion that the patient experiences). DI is classified as a delusional disorder, somatic type in DSM-5 (diagnostic criteria in Table I). Comorbid psychiatric disease, especially depression, anxiety, and substance abuse, is common.[5]

Epidemiology. The prevalence is 5.58 cases per million persons in the hospital and public health setting, and 83.23 per million persons in the private practice setting.[6] Age of onset is bimodal, with a peak prevalence in patients 20 to 30 years of age and >50 years of age.[7] There is a 2:1 female to male ratio among patients >50 years old.[7] Approximately 8% to 12% of patients demonstrate folie à deux (ie, share symptoms with a friend or relative).[8]

Clinical features and evaluation. Patients often describe cutaneous dysesthesias attributed to the infestation, such as crawling, biting, and stinging ("pins and needles" sensation), and elaborate lifecycles of their "parasites."[9] About half of the patients present with the "specimen sign," where they bring specimens (eg, skin particles or hair, and rarely insects) as proof of infestation.[10] Patients use eradication that involves the use of pesticides, disinfectants, and topical medications to cure the infestation. Extraction attempts are common, because patients try to remove the organisms with fingernails or tools, producing self-imposed erosions, ulcers, prurigo nodules, and lichenification (Fig 1).[7,9] Patients isolate themselves from friends and family for fear that they can contaminate others.[7,9]

The diagnosis of DI can be established based on the clinical features and history, and after ruling out other etiologies, such as primary skin disease (eg, scabies and bite reactions).[9] Primary formication—the sensation of bugs crawling on the skin (without the belief of infestation) that is often caused by underlying neurologic disease or substance abuse—should be excluded. It is important to rule out other psychopathologies, because DI may occur as a result of an underlying psychiatric disorder or a global mental illness.[9] In addition, dementia, malignancies, cerebrovascular disease, vitamin B12 deficiency, and systemic disorders causing pruritus can produce organic psychosis with formication. Appropriate laboratory evaluations should be performed.[5,9]

Management. The first step is building a strong therapeutic alliance with patients that notoriously lack insight and often reject psychiatric care. The goal of the visit is to improve the patient's condition, not to convince the patient that they are delusional; physicians should neither challenge nor confirm the delusion.[7] Performing initial laboratory tests, obtaining skin biopsy specimens and cultures, and examining patient specimen samples help rule out organic causes of formication and build rapport.[7,9] Once trust is established, patients can be offered antipsychotic agents. Historically, the treatment of choice has been pimozide (1-10 mg/day).[9] Because of pimozide's extrapyramidal adverse effects, atypical antipsychotic agents, such as risperidone (0.5-6 mg/day), olanzapine (2.5-20 mg/day), quetiapine (25-600 mg/day), and aripiprazole (2-30 mg/day), are increasingly used.[11] Patients with DI often respond to lower doses of antipsychotic medication than patients with schizophrenia or other psychotic disorders. An improved clinical outcome can be achieved in patients who are engaged in antipsychotic treatment.[12]

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