Introduction

Some cutaneous disorders are related to psychiatric or psychological distress and also some psychiatric disorders are associated as comorbidities with skin diseases or other common diseases as high blood pressure, heart diseases. Our purpose was to present a case of possible comorbidity between Facticial dermatitis and Tinea corporis.

Case presentation

A 56 year old woman presented with a seven month history of intense pruritus on her arms. She reported that, after her divorce, she noticed something moving on her arms; she also reported an intense pruritus mostly during her daily rest periods and absent during the night when the lesions often heal. The physical examination revealed linear scratching lesions, erythematous areas, ulcerations, scars and linear pigmented with a parallel pattern on the external part of her arms and forearms (Figure 1.a) (Figure 1.b). The most affected site was the left external area of the arm, because she was right-handed, and there were no lesions on the back. The regional skin was a little bit dry and very sensitive when touched. The laboratory investigations were normal, including the bacteriological examination from linear wounds. Asymptomatic or slight pruritic raised concentric red rings with a central area of clearing and covered by scales were identified on the calfs (Figure 1.c). Direct mycological microscopy (with KOH) of scales scrapings was negative, but the mycological culture was positive for Microsporum canis. A presumptive diagnosis of Factitious dermatitis and Tinea corporis was made.

The patient underwent empirical topical treatment with emollients, calamine and silver sulfadiazine cream, antihistamines, antidepressant therapy with doxepin 25 mg at night for the first condition (1). For Tinea, a topical clotrimasole cream twice daily and terbinafine 250 mg daily was prescribed as a four weeks regimen. After four weeks of treatment, the number of the Tinea’s circles diminished to one.

Keywords:
lines, dermatitis artefacta, Microsporum, circles, glabrous skin
on the interior calf (Figure 1.d) and after two more weeks the lesion vanished, but there were no improvements in patient’s outcome regarding linear skin lesions of the arms, maybe due the terbinafine interaction with doxepine (2, 3). She was referred to psychiatry for a consultation with a psychosomatic specialist. After the establishment of an appropriate psychiatric treatment, she was lost for the dermatological follow-up for one year. After one year, she presented again with linear scratching lesions, erythematous areas, ulcerations, and scars, but without Tinea circular lesions.

Discussion

Usually, Microsporum shows a predilection for the hair follicle, but in the presented case the glabrous skin was involved. There are very few studies regarding the association between psychiatric induced skin disorders and fungal infections of the skin (4, 5). It is difficult to say whether the wounds were entrance doors for Tinea or Tinea stressed the induction of linear lesions. Caution should be exercised when co-prescribing terbinafine and drugs metabolized by CYP2D6, particularly those with a narrow therapeutic index (2). Given the particularity of this case and the fact that there are few studies that demonstrate a direct relation between psychiatric pathology and fungal skin pathology, we consider it is opportune to report this case in order to draw attention on this possible association.

Conflicts of interest: none declared.

There are no funding sources that supported this work/article.

Bibliography


Figure 1a. Dermatitis artefacta left arm
Figure 1b. Dermoscopy of dermatitis artefacta
Figure 1c. Tinea corporis on the calf
Figure 1d. A single Tinea circle