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SKIN PICKING: A PRACTICAL APPROACH FOR THE BUSY DERMATOLOGIST

There is often a sense of dread when a dermatologist receives a referral for skin picking or excoriations. Due to the nature of our practices, these referrals typically suggest a longer visit, a frustrated patient, and ultimately, a less-than-satisfying visit for all parties involved. How can this be minimized?

There are many reasons why a patient might manipulate their skin including an underlying dermatologic condition or neurologic abnormality, pruritus without a rash, medication or drug abuse, and psychiatric illness. As a practicing dermatologist, a patient who presents with an underlying dermatologic condition is relatively easy to identify and diagnose as these cases of skin picking are usually related to an underlying inflammatory dermatosis, infection, or infestation. Similarly, systemic illnesses leading to pruritus without a rash and underlying neurologic abnormality are equally easy to identify and diagnose. An important neurologic condition to rule out, which may lead to skin picking is dementia. The dermatologist should also be familiar with identifying medications and/or recreational drugs of abuse that may lead to itching and subsequent picking. This, then, leaves the category of psychiatric illnesses. Excoriation (skin picking) disorder is listed in the DSM-V as follows[1]:

A. Recurrent skin picking resulting in skin lesions.
B. Repeated attempts to decrease or stop skin picking.
C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The skin picking is not attributable to the physiologic effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypes in stereotypic movement disorder, or intention to harm oneself in non-suicidal self injury).

For the practicing dermatologist, the above criteria can be difficult to remember. Instead, it may be easier to approach the patient according to the primary psychopathology: delusional, depressive, anxious, or obsessive-compulsive, which may help guide the management approach. It is important for the dermatologist to be reminded that one of the most important aspects to the successful management of these patients involves the building of rapport. Recognizing that there is no single "right" way, it is important to develop one's own style of interacting with these patients. For example, empathic listening while the patient details their difficulties may be very therapeutic for many of these patients who can feel as though their concerns may not have always been previously heard. At the same time, it is important to remain neutral and avoid speculation pertaining to the potential underlying cause of the patient's lesions.

A thorough physical examination is critical to ensuring an accurate diagnosis. All skin lesions should be reviewed, specifically looking for primary lesions suggesting an alternative diagnosis. Patients with delusions of parasitosis often display the "matchbox" or "baggy" sign containing collected samples, often containing keratinaceous debris or bits of dried blood. This is thought to be pathognomonic of this condition. However, it is important that the dermatologist actually review these samples to ensure there are not samples of arthropods that can actually cause a bite reaction, such as a bedbug.

Sometimes, a patient will bring in an insect that is thought to represent the culprit organism. If a specimen is sent off for identification, it is important to stipulate on the lab requisition that you are looking for an organism known to bite/infest humans.

As practices are busy, it is important to arrange short, but frequent visits for these patients. Although there may be a desire to refer these patients out for psychiatric assessment, it is critical to have an established relationship with mental health clinicians within your network. This is particularly important in delusional patients. The majority of our mental health colleagues have not seen these types of patients and their lesions and it is quite easy for unfamiliar mental health professionals to mistake the lesions as being infectious in nature. A single psychiatric assessment suggesting the lesions are "infected" can significantly delay the care some of these patients need.

The key to identifying a delusional patient is that they often articulate a firm belief that something is causing their lesions. Unfortunately, management of these patients is particularly challenging as they lack insight with respect to any underlying psychiatric condition. For patients who agree to a course of medication, antipsychotics are the recommended first-line treatments. Pimozide is a first-generation antipsychotic which has limited peer-reviewed data to support its use in patients with delusions of infestation, however, due to concerns with potential side effects, second generation antipsychotics are suggested.[3] Risperidone and olanzapine are the most commonly prescribed second-generation antipsychotics for this condition with risperidone being favored over olanzapine given that the latter has greater documented risk of weight gain and metabolic syndrome.[4] Aripiprazole, a newer third-generation antipsychotic, has also demonstrated some success in these patients as evidenced by several case reports supporting its use.[5,6]

Non-delusional patients are usually easier to identify and treat as they are able to provide significant insight as to the underlying cause of their lesions and they are also usually agreeable to treatment. These patients may often present with an overlap of various other psychiatric conditions such as depression with anxiety, anxiety with depression, depression and anxiety with obsessive-compulsive traits, obsessions and/or compulsions leading to depression and anxiety due to frustration, to name a few. These patients will often require combination treatment modalities.[7] Clinicians should select a therapy that addresses the most prominent psychiatric symptom as a starting point. For example, antidepressants when depressive symptoms predominate, anxiolytics when anxiety symptoms predominate; and anti-obsessional and/or anti-compulsion agents for obsessive-compulsive symptoms. After a few weeks, depending on patient response, the addition of adjunctive agents may be warranted.

For patients with depression necessitating pharmacotherapy, selective serotonin reuptake inhibitors (SSRIs) are still recommended as first-line agents, however clinicians may also wish to consider noradrenaline and dopamine reuptake inhibitors (NDRIs) as an alternative first-line agent.[8] These agents may also be used as anxiolytics. Clinicians should be mindful that since the time between initiation of therapy and optimal response may take some time with these classes of drugs, patients with significant

anxiety issues may be candidates for benzodiazepines while bridging to these agents. SSRIs are very versatile agents and at higher doses, these agents may also be useful in patients with obsessive-compulsive disorders. At our combined psychiatry-dermatology clinic, however, we have found clomipramine, at lower, non-antidepressant dosages, to be very useful.[9] This agent was the first drug used in the treatment of obsessive-compulsive disorders and is indicated for patients ten years of age and older.[10]

In summary, many patients present with excoriations to the dermatologist with the majority of these patients having an underlying dermatologic condition or systemic illness that can be identified as the trigger for their skin picking. Clinicians treating these patients should be reminded that medications and recreational drugs can also contribute to this problem. In order to help the busy clinician manage these rare patients who present with a psychiatric cause for their excoriation disorder, it is important to identify the major psychiatric symptom. Once that has been identified, a targeted therapy will allow for appropriate management of these patients and aid in ensuring an optimal outcome.

Antipsychotics*

Drug	Start	Range	Monitoring	Notes
Aripiprazole	5 mg daily	5-30 mg daily		Lower risk of extrapyramidal side effects and weight gain
Olanzapine	2.5 mg at bedtime	20 mg daily		High risk of weight gain and metabolic syndrome
Pimozide	1 mg daily	1-6 mg daily	Pre-treatment EKG	Higher risk of extrapyramidal side effects; risk of cardiac death with prolonged QTc
Risperidone	0.25-0.5 mg daily	1-6 mg daily	Consider prolactin levels	Lower risk of extrapyramidal side effects; may increase prolactin levels

** For antipsychotics in general, it is important to obtain baseline lipid, body mass index, waist circumference, and hemoglobin A1c*

Antidepressants†

Drug	Start	Range	Notes
Escitalopram	5 mg daily	10-20 mg daily	Cannot use with tricyclic antidepressants or monoamine oxidase inhibitors; few side effects; few drug interactions
Sertraline	25-50 mg daily	50-200 mg daily	Cannot use with tricyclic antidepressants or monoamine oxidase inhibitors; few side effects; few drug interactions
Venlafaxine	37.5-75 mg daily	75-225 mg daily	May be activating; watch blood pressure

† Like most antidepressants, it may take several weeks before benefits show; start low, go slow

Anxiolytics§

Drug	Start	Range	Notes
Escitalopram	5 mg daily	10-20 mg daily	Cannot use with tricyclic antidepressants or monoamine oxidase inhibitors; few side effects; few drug interactions;
Sertraline	25-50 mg daily	50-200 mg daily	Cannot use with tricyclic antidepressants or monoamine oxidase inhibitors; few side effects; few drug interactions;

§ Like most anxiolytics, it may take several weeks before benefits show; start low, go slow

Anxiolytic (acute management)

Drug	Start	Range	Notes
Clonazepam	0.25 mg daily	0.25 mg b.i.d. to t.i.d.	Max dose is 4 mg, but for dermatologists, given the addiction potential, I would suggest keeping max dose at 2 – 3 mg daily; t1/2= 30-40 hours

Anti-OCD

Drug	Start	Range	Monitoring	Notes
Clomipramine	12.5-25 mg daily	12.5-150 mg daily	None; routine	Assess overdose risk as may be lethal; mostly anticholinergic side effects: dry mouth, sleepiness, and weight gain; cannot use in combination with SSRIs; average dose 75 mg daily, titrate by 25 mg every 1-2 weeks
Escitalopram	5 mg daily	Closer to 20 mg daily	None; routine	Cannot use with tricyclic antidepressants or monoamine oxidase inhibitors; few side effects; few drug interactions; same range for anxiety management
Sertraline	25-50 mg daily	Closer to 200 mg daily	None; routine	Cannot use with tricyclic antidepressants or monoamine oxidase inhibitors; few side effects; few drug interactions; same range for anxiety management

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