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Original Article

Skin disorders in patients with primary psychiatric conditions

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Abstract

Objective To determine the frequency of skin dermatosis in patients with primary psychiatric conditions.

Methods This cross-sectional study was conducted in the Fountain House, Lahore, which is a tertiary care center for psychiatric patients having indoor and outdoor facility. All the admitted psychiatric patients (294) were enrolled in the study. They were thoroughly examined for any skin dermatosis. Out of 294, skin disorders were seen in 172 (58.5%) patients, 89 (60.6%) males and 58 (39.4%) females. The most common primary psychiatric conditions was schizophrenia 47.5% followed by patients of substance abuse 26.5%, bipolar disorder 13.1%, depression and psychosis each in 8.2%. 2.7% patients were manic. Of the study group, 16.3% patients had infective dermatoses and the rest had noninfective dermatoses. A high incidence of generalized xerosis and pruritus was seen in both males and females. Among noninfective dermatoses, 10.1% had eczema, 6.2% acne, 5% melasma, 4.1% palmoplantar keratoderma, 3.2% neurotic excoriations, 3.2% dermatitis artifacta, 2.7% trichotillomania, 2.1% miliaria, and 1.4% had ichthyosis.

Conclusion A high incidence of fungal infections mainly tinea versicolor and onychomycosis was seen in the patients with primary psychiatric conditions.

Keywords
Psychiatric patients, skin disorders.

Introduction

The relationship between the psychology and skin is undeniable.[1] Stress, anxiety and depression has been found to contribute to the severity of pre-existing dermatosis like acne, psoriasis or atopic dermatitis or they can lead to the development of so called psycho cutaneous changes which can be challenging and frustrating for clinicians as well as patients. Psychosocial factors should be considered in mind while treating the dermatological disorders, similarly in patients with primary psychiatrist disorders, dermatological problems should be managed effectively.[2,3] The published data on the frequency of dermatoses in such patients is not much.

Methods

This study was conducted during August, 2014. In this study all the patients admitted in the Fountain House, Lahore for their primary psychiatric condition were enrolled. A detailed dermatological evaluation was carried out in all patients. Relevant investigations like scraping for fungus and biopsy were done when required. The information was duly documented on a proforma and compiled.

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Results

Out of 294 patients, skin disorders were seen in 172 (58.5%) patients with primary psychiatric conditions. Of these, 89 (60.6%) were male and 58 (39.4%) were female patients. The most common primary psychiatric conditions were schizophrenia in 47% followed by patients of substance abuse in 26.5%. Bipolar disorder was seen in 13%, depression and psychosis were present in 8.2% and 2.7% patients, respectively (**Table 1**).

Of the study group, 16.3% patients had infective dermatoses and the rest had noninfective skin disorders. A high incidence of generalized pruritus (25%) and xerosis (17%) was seen in both male and female patients. Noninfective dermatoses included eczema (10.1%), acne (6.1%), melasma (5%), palmoplantar keratoderma (4.1%), miliaria (2.1%), and ichthyosis (1.3%) [**Table 2**].

Regarding psychocutaneous disorders 3.2% had neurotic excoriations. Dermatitis artefacta and trichotillomania were seen in 3.2% and 2.7% patients, respectively (**Table 2**).

Among infective dermatoses, a higher incidence of dermatophyte infections 6.1% was noted in the study group. Among the fungal infections, onychomycosis, pityriasis versicolor and tinea corporis were mostly seen.

Parasitic infestations were seen in 7% of the study group patients. Of these, scabies was present in 5% and pediculosis capitis in 2%.

Table 1 Distribution of common primary psychiatric disorders (n=294).

Psychiatric disorders	*Male*	*Female*	*Total*
Schizophrenia	20%	27%	47%
Addiction	20%	6.5%	26.5%
Bipolar disorder	7%	6%	13%
Depression	3%	5.16%	8.16%
Psychosis	1%	1.72%	2.72%

Table 2 Distribution of skin disorder in the study group (n=172).

Skin disorders	*%*
Infective dermatoses	
Pediculosis capitis	15 (9.0)
Dermatophytic infections	10 (6.1)
Scabies	8 (5.0)
Non-infective dermatoses	
Pruritus	47 (25.0)
Xerosis	30 (17.0)
Eczema	17 (10.1)
Acne	10 (6.2)
Melasma	9 (5.0)
Palmoplantar keratoderma	7 (4.1)
Miliaria	3 (2.1)
Ichthyosis	2 (1.3)
Psychocutaneous disorders	
Neurotic excoriations	5 (3.2)
Dermatitis artefacta	5 (3.2)
Trichotillomania	4 (2.7)

Discussion

Early in this century there was a consensus on a point that skin of most of the patients suffering from mental illnesses was unhealthy and diseased directly or indirectly. Lynch 1945 said that certain cutaneous manifestations appear to be the evidence of psychobiological imbalance. Our study was to see the occurrence of cutaneous lesions in a mentally ill population and to assess the skin diseases associated with the infective and dietetic hazards peculiar to institutional life.[4] Schizophrenia and patients of substance abuse in the present study, does not corroborate with other studies,[1] where depression and anxiety were the most common primary disorders. This may be due to the fact that our study population comprised of admitted patients and anxiety and depression are mostly treated on outpatient basis. Acne and melasma were seen mostly in female psychiatric patients, Acne excorie was particularly seen in female patients suffering from schizophrenia. Acne excorie has been reported before with phobic states,[5] depression and delusional disorders.[6] Among the infective dermatoses, fungal

infections were seen more frequently probably due to the humid environment of our region. Superficial fungal infections were seen more in male than female psychiatric patients The hygiene of female patients was much better than male patients so increase occurrence of fungal infections in male may be attributed to poor personal hygiene and negligence. In our study, most of the patients suffering from fungal infections were schizophrenics.

Delusional parasitosis affects both sexes equally below the age of 50[7] and is associated with schizophrenia,[10] paranoid states, bipolar disorders, depression, anxiety disorders and obsessional states.[2] In our study, delusional parasitosis was seen in female schizophrenic patients and this is comparable to the study conducted by Kuruvila *et al*.[9] in India. Due to immature personality, dermatitis artefacta is commonly seen in adolescents and in this patient wants to get attention of others.[10] Dermatitis artefacta has been reported most commonly in females and in the early adult group. Same age and sex distribution was seen in our study. Dermatitis artefacta was seen in patients of substance abuse and schizophrenia. Although patients with trichotillomania typically present to dermatologists, the diagnosis and treatment lie in the field of psychiatry. Graber and Arndt[11] found that 7% of patients associated their hair pulling with a recent stressful event. It was noted that 26% of patients had surgery or trauma, and 47% reported a related stressful event. Trichotillomania has a bimodal age of presentation and 43% of the patients deny that their alopecia is induced by themselves.[12] In our study trichotillomania was seen 3.2% of the patients with a female preponderance and these patients were suffering from severe depression. Neurotic excoriations were seen in 3.2% of the study group. The most common co-existing psychiatric conditions were major depression and anxiety disorders. The connection between psychiatry and dermatology is evolving and increased understanding of these complex issues is required.

More prospective case control studies are required to provide more insight in to this interesting field and to further document and substantiate the results of our study.

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