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Education

Skin picking disorder: what can we learn from such a topical issue?

EDUCATION

AUTHOR

George Alexander Johnson
King's College London

Dean Joseph Connolly
University College London

Dr Jon M.R Goulding
Heart of England NHS Foundation Trust

Address for Correspondence:

Dr J.M.R Goulding

Birmingham Heartlands Hospital
Bordesley Green East
Birmingham B9 5ST

Email: jon.goulding@heartofengland.nhs.uk

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ABSTRACT

Summary

Skin picking disorder (SPD) is a psychodermatological condition characterised by repeated pathological picking of the skin, creating recalcitrant excoriated skin lesions. As well as the physical manifestations of skin picking, SPD carries with it a host of debilitating social, psychiatric and medical sequelae, which greatly impairs quality of life in sufferers. It is clinically challenging to make an accurate diagnosis of SPD and, in our experience, successful management requires a sensitive and holistic biopsychosocial approach involving a psychodermatology multidisciplinary team.

Relevance

The prevalence of SPD is ~2-4%, yet fewer than 20% of sufferers feel that their clinician 'knew much' about their condition. This must be immensely frustrating for sufferers, and it chimes with research suggesting that medical students, and by extrapolation doctors, have multiple gaps in their knowledge of psychiatric disorders, patients and treatments. We believe that a greater emphasis on psychiatry in medical training is long overdue, particularly to highlight the crucial importance of addressing psychosocial factors alongside physical symptoms in all patients.

Take Home Messages

1. SPD is an under-diagnosed and often poorly managed condition that is associated with clinically significant distress or impairment in multiple areas of day-to-day functioning.

2. Given the wide differential diagnosis for SPD, a careful history, physical and mental state examination is critical in making an accurate diagnosis.

3. SPD lacks a standardised treatment protocol, but successful management can be achieved through involvement of a psychodermatology multidisciplinary team.

4. Psychosocial illness is poorly understood by the typical medical undergraduate. Medical schools must strive to remedy this by placing a greater emphasis on the importance of holistic assessment and treatment in all patients.

Skin picking disorder (SPD) is a psychodermatological condition reported in medical literature from as early as 1875. (1) The disorder is characterised by repeated pathological picking of the skin to the extent where lesions are apparent across accessible sites such as the face, neck, arms and scalp. SPD carries with it a host of extremely debilitating social, psychiatric and medical sequelae, and as such, greatly impedes quality of life in sufferers.

Despite historical recognition of SPD and its serious complications, the disorder only became officially recognised in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) in 2013. The exact aetiopathogenesis underpinning SPD remains unclear, but the evidence implicates both genetic and environmental components. (2) Rodent models have identified some candidate genes, which appear to converge on dysregulation in the neural circuitry involved in habit generation and top-down motor inhibitory control processes. (1)

Picking behaviours vary within and between sufferers but are typically highly ritualised, and triggered by stress, anxiety or boredom. Patients also report feelings of mounting tension prior to picking, with relief and even pleasure experienced during or immediately afterwards. The psychosocial component of SPD is severe, with many sufferers avoiding daily activities that may expose their skin such as work, sport and social commitments. The isolation that follows compounds the problem further by allowing more time for skin hypervigilance, picking and unfortunately frequent suicidal ideation. Medical sequelae include bleeding, localised infection, septicaemia, scarring and, in the most severe cases, an increased risk of mortality warranting neurosurgical intervention. (3)

From the clinician's point of view, the priority in assessing patients with possible SPD is to actively exclude a primary organic disorder. Systemic causes of pruritus must be ruled out, such as iron deficiency anaemia, diabetes mellitus and coeliac disease. Primary organic dermatoses such as scabies, as well as other related yet distinct psychodermatological conditions e.g. dermatitis artefacta, must also be distinguished. There is also the challenge of separating SPD from common psychiatric co-morbidities that may better explain the skin picking. These include body dysmorphic disorder and psychotic disorders involving skin-related delusions and tactile hallucinations. In light of this, a mental state examination is crucial to making an accurate diagnosis.

SPD currently lacks a standardised approach to management. Evidence in the literature demonstrates a significant benefit for behavioural, but not pharmacological therapies, as compared to placebo. (4) Skin directed therapies should always be employed in conjunction with psychiatric or psychological treatments for dual purpose: to treat infection or dry skin if indicated, but also to reassure patients unwilling to consider psychosocial factors that their problem is being taken seriously. In our experience, successful management requires a sensitive and holistic approach that, looking forward, may best be delivered in a specialist multidisciplinary psychodermatological clinic.

The prevalence of SPD is ~2-4%, however, studies have revealed that less than 20% of afflicted patients felt that their clinician 'knew much' about their condition. (4,5) Whilst this must be frustrating for sufferers, it also raises a myriad of questions surrounding medical education.

Medical students are all too familiar with the endless lists of rare mutations that lead to conditions never-to-be-seen on the wards. Studies have found that medical students have multiple lacunae in their knowledge toward psychiatric disorders, patients and treatments. (6) This both fits with the aforementioned issues with SPD and is something that medical students experience throughout their studies.

There is a complex interplay between psychiatry and the medical and surgical specialties that all practitioners need to be aware of. Failing to understand this dynamic is a compromise of one's duty of care, and creates a potential hazard for our patients. A simple example of this lies with individuals who attend A&E with self-harm injuries. Patients are often labelled as 'frequent flyers' and it is unfortunately accepted throughout the literature that analgesia is rarely offered, with one patient being told 'I thought you liked pain'. (7) This represents a physical manifestation of psychiatric disease and the poor treatment of these patients likely represents poor understanding of the full clinical picture, as discussed above with SPD.

Medical students depend on their education to build a career that needs to be fundamentally safe and improve the lives of patients. It is the joint responsibility of both students and their seniors to acknowledge the importance of these newly classified disorders. We therefore deserve autonomy over the content of our education. Whilst we acknowledge that there are mounting pressures on medical education, we suggest the following moving forward:

- A greater emphasis on psychiatry, including niche disorders that are commonly overlooked in typical undergraduate programs.
- Considering the feasibility of psychiatry as a compulsory component in the foundation program.
- Medical schools to place greater emphasis on the uses and benefits of cognitive and behavioural therapies.

It is our hope that consideration of the above will raise awareness of some of the pitfalls that we face as the new generation of medical professionals. It must be frustrating for patients who often have no choice through which lens we view their disease. We believe a holistic biopsychosocial approach should be promulgated in all patients to a greater or lesser extent, to ensure that organic disease is not missed, and that psychosocial illness is given the credence it

deserves.

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