CHAPTER 17

Occupational Dermatitis Artefacta

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Introduction

The term “dermatitis artefacta” was coined in 1908 by the writer Paul Bourget, who had been asked by a dermatologist to define the peculiar behaviour of one of his patients. This patient, aged between 30 years and 40 years, had self-inflicted gangrene of a limb using potassium hydroxide and had managed to deceive various doctors as to the nature of his complaint (Dieulafoy 1908).

The classification of self-inflicted dermatoses is still very vague. They come under the heading of simulated or artefactual diseases (Table 1), the best-known example of which is Munchausen’s syndrome (Asher 1951; O’Shea 1984; Janofski 1994). In their turn, self-inflicted skin conditions can be subdivided into various clinical forms (Table 2). Dermatitis artefacta is one of the most important of these pictures (Lyell 1979; Fabisch 1981; Van Moffaert et al. 1985; Consoli 1995).

Table 1. Simulated diseases

| Munchausen’s syndrome | Self-inflicted dermatoses | Self-mutilations | Vulvodynia | Glossodynia | Factitious pyrexia |

Table 2. Self-inflicted dermatoses

| Dermatitis artefacta | Pathomimic artefacts | Heteropathomimic artefacts | True simulation | True heterosimulation (“witchcraft syndrome”) | Behavioural disorders | Neurotic excoriations | Acne excoriée | Trichotillomania | Onychotillomania | Factitious chelitis | Callosities of the hands | Dermatological pathomimicry | Painful bruising syndrome | Psychogenic purpura | Religious stigmata |

Definition

Dermatitis artefacta is a self-inflicted complaint provoked by the patient for various purposes and by various means. Artefact diseases can in fact be provoked in almost all organs by means of exogenous or endogenous mechanisms. In reality, the latter solution is rarely adopted because it can be seriously dangerous and is difficult to control over time, providing inconsistent and ungovernable clinical evidence. The exogenous mechanism is much more frequently resorted to, with the skin as the target organ. Such simulators can choose the site to be affected carefully and avoid damaging the whole organism; the self-inflection can be suspended at the desired moment and, above all, the disease is “obvious” to all. The latter characteristic paradoxically justifies the very existence of these artefact dermatoses.

In contrast, in other subjects, the simulated disease is due to psychiatric problems such as psychoses, mental retardation and personality disorders. In these cases, the intrinsic reason for the lesions is different, as the subject generally hopes to attract the attention of the people he is surrounded by and of the doctor, or else he is reacting to difficult or unfavourable environmental conditions with involuntary somatisation at the skin level. These unconscious simulators are prevalently female.

Artefact skin diseases for illicit purposes, aiming to gain some advantage, are true simulations. Lesions
provoked by subjects with psychological disturbances, i.e. irresponsibly and without a venal interest, are described as pathomimic (a term which really refers to faithful imitations of known diseases and, in dermatological terms, only to simulations with a psychological basis). In this chapter, only true simulations for professional purposes will be examined.

**Diagnostic Criteria**

The diagnosis of dermatitis artefacta does not usually present particular difficulties, despite the fact that the dermatologist cannot rely on precise anamnestic data or the patient's collaboration. The diagnostic criteria are described below.

**Site**

The lesions are usually localised in areas exposed to the possible action of occupational risks and of easy access, such as the left arm (or the right if the simulator is left handed), the lower limbs, the anterior region of the chest, the abdomen and, rarely, the face (but almost exclusively in cases of pathomimic, psychologically-induced simulations) and the neck. The back is usually left alone, unless the simulator can persuade a friend to collaborate (obviously, provoking the same type of lesions as in the other sites), so as to prove the spontaneous nature of the clinical form.

**Morphology**

Unlike spontaneous lesions, those of dermatitis artefacta do not usually present a rounded or oval appearance, conforming with the skin irritation cones. They are generally irregular, occasionally even having a bizarre, decorative appearance, with clearly defined margins, broken lines and acute angles. They are sometimes noticeably linear, or monomorphic, with little involvement of the surrounding skin. Often, particularly in cases of ulcerous or ulcero-escharotic lesions, there is a distinct pattern visible, which reproduces the shape and size of the object used to inflict the lesions. Ulcerative lesions can have well-defined margins, a base infiltration of greater or lesser extent, and are often surrounded by erythematous, oedematous skin, a clear sign of inflammation due to physical or chemical aggression. In oedema from interrupted blood flow, signs of arrest at the ligature point are often evident together with an identical, hard consistency along the whole length of the region involved.

**Lesions**

Virtually all elementary lesions can be observed, perhaps excluding nodules, gummata, atrophy and sclerosis. Erythematous lesions are usually livid or cyanotic with clear-cut margins; purpuric lesions, usually due to suction or stricture from bandaging, and excoriations are also frequently observed. Vesicular lesions are rare, whereas irregular bullous lesions are quite common, caused using vegetable extracts or chemical substances (Fig. 1); these lesions are sometimes rounded, having been induced by suction (Dufton and Griffiths 1981). Pustules are often secondary to infection of previously inflicted lesions, or due to contact with contaminated objects, or methodical scratching with infected nails. Ecchymoses with sharp margins are often observed, procured by repeated trauma from pinching or beating with various objects (wooden sticks, sand bags).

Subcutaneous introduction of various substances (paraffin, milk) gives rise to infiltrating lesions, which can later take on a wooden consistency (paraffinomas) and may evolve into ulcers. Pigmented lesions with linear borders can be an outcome of previous erythematous manifestations. Ulcerous or ulcero-escharotic lesions are very commonly observed (Fig. 2), whereas gangrenous lesions of the legs, with irregular contours, are less frequent. In the latter case, the normal surrounding tissue and integrity of the annexes can help to exclude a vascular origin of the affliction.

![Fig. 1. Bullous and escharotic lesions from chromic mixture. Similar lesions were present at other sites](image-url)