A Note from the Editors

DERMATOLOGY + PSYCHOSOMATICS is a journal dedicated to a high scientific standard. Therefore, a review process is a prerequisite for publication of manuscripts. Nevertheless, the editors of the journal feel the need to offer a platform for comments which can be printed without the demand for corrections and adaptation to rather formalistic criteria. To provide the opportunity for the presentation of 'methodologically unstandardized' spontaneous observations in clinical practice / of clinical experience or comments concerning previously published articles we maintain the section 'Letters to the Editors' to hereby encourage the interaction among psychodermatology researchers and clinical practitioners. We would be pleased to promote a discussion within the context of psychodermatological issues in a broad sense and to contribute to interdisciplinary discussions.

Furthermore, the section 'Letters to the Editors' can be used to give feedback on articles published in the latest issues of the journal. We are grateful for comments with respect to methodological aspects of the treatises as well as to the results or conclusions drawn by the authors. We hope that the new section will be taken up by interest and will contribute to a lively and interesting discussion.

Malingering of Scrotal Dermatitis

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Key Words

Scrotum · Dermatitis artefacta · Malingering

Summary

A patient with prolonged self-inflicted injury of the scrotum is described. Both social and emotional factors were important in the pathogenesis of his dermatitis.

Introduction

Dermatologists are often faced with psychological and psychiatric problems, including patients with self-inflicted dermatoses [Cotterill and Millard, 1998]. While in some patients the diagnosis of dermatitis artefacta is obvious, in other instances the patient may evade a correct diagnosis, often successfully deceiving many doctors for many years. In short, well-intentioned doctors find it difficult to accept that a patient may deliberately set out to deceive his/her medical advisors.

In females dermatitis artefacta is best interpreted as unconscious cry for help, in males, however, the damage to the skin often occurs consciously with an object of malingering [Consoli, 1995; Lyell, 1979]. Some patients even simulate established skin diseases by physical manipulation of the skin (dermatological pathomimicry, Millard's Syndrome) [Millard, 1984].

Case Report

A 45-year-old lorry driver, married with one child, presented with non-healing erosions of the scrotum. The patient complained of pruritus which was intense enough to induce compulsive scratching and, although the problem had been present for 11 years, he denied any difficulties with sexual intercourse. The patient had been admitted on four occasions since 1991 to different departments in different hospitals because of scrotal problems and had been treated with systemic antibiotics, anti-inflammatory agents and topical steroids. An initial skin biopsy in 1991 showed chronic inflammatory change with granulation, and a skin biopsy carried out 2 years later by a urologist on an ulcerated area on the scrotum showed similar changes. In 1996, the patient was admitted to the surgical

Fig. 1. Scar-like firm lesions of scrotum with erosions.

Fig. 2. Cicatrization of the skin, H&E $\times 100$.

oncology ward where a diagnosis of scrotal ulceration complicating neurodermatitis was made. A third biopsy was taken, demonstrating epidermal acanthosis. The ulcerated area on the scrotum was excised. Systemic treatment was given with prednisolone, tetracycline, dapsone, mianserin, antihistamines and other oral and topical antibiotics, according to sensitivities. Extensive investigations at that time did not reveal any other underlying medical problems. A scrotal fistula developed and a mixed bacterial population was found on culture, including *Streptococcus epidermidis*, *Staphylococcus aureus* and *Enterococcus faecalis*.

After a further exacerbation the patient was admitted to the Department of Dermatology of the Medical University of Lodz in December 2000 with scarred lesions, erosions, crusts and lichenification of the scrotum (fig. 1). Histologically, the predominant feature was scarring (fig. 2). Extensive investigations were negative and considerable initial improvement to the scrotum was noted after topical antibiotic and steroid therapy. Subsequently, there was worsening of the disease in hospital especially after encouraging news of clinical improvement from the patient's medical advisors.

It is not possible to comment on the background or unconscious dynamics in the patient as any attempt to explore this problem was blocked. Superficially, the 'pay off' was economic. Besides, he had the benefit of being the centre of attention in the sick role. Moreover the patient's impotence was legitimised in a way easily understood by his wife.

Discussion

The clinical features of dermatitis artefacta have recently been reviewed [Joe et al., 1999; Koblenzer, 2000; Harman et al., 2001; Consoli, 2001; Pascual et al., 2001; Leonardou et al., 2002]. Also aggression directed specifically at the genital area has been investigated by Agoub and Battas [2000] and Kelemen et al. [2000]. Our patient, a man with an 11-year history of scrotal lesions presenting mainly as erosions, ulceration and neurodermatitis fits best in the diagnostic category of genital auto-aggression. For instance, the clinical features were not those of any well-established organic skin disease. The clinical picture was characterised by a sudden deterioration of the disease, especially following any encouraging news from the doctors about improvement in the area. Such changes strongly suggested the possibility of conscious self-manipulation. Men are particularly liable to induce dermatitis artefacta con-

sciously as a form of malingering. The benefit for our patient was that he had a ready excuse for his impotence in that he could refrain from sexual intercourse. Moreover, the patient's wife reported that she understood that he had to refrain from sexual intercourse on account of his skin problems.

The patient associated his skin problems with his work and claimed that his scrotal disease made his work uncomfortable and even dangerous. He was therefore able to use his scrotum as an excuse for absence from work and also for unemployment benefit, and even for a disability pension.

The patient, however, rejected any suggestions of a psychological nature of his problems and refused any psychiatric referral. It is a clinical irony that those patients most in need of psychiatric help are the ones most likely to decline such advice.

Clinically, the skin lesions were superficial, extensive and irregular but did not present a distinct geometrical, linear shape as is the case in many self-induced skin lesions. However, there were no signs of organic skin disease and all investigations, especially skin biopsies, only showed the changes of a non-specific chronic ulceration.

There were certain similarities in this case to patients described with scrotal nodular lichen simplex, although these patients were apparently successfully cured by surgical excision of the lesions [Porter et al., 2001] which was unsuccessful in our patient. In summary, a man with scrotal malingering is described. The benefits to the patient due to this self-inflicted disease were not only to legitimise his impotence but also to provide an excuse to avoid work and claim disability benefits. Due to an unbridgeable gulf in communication between doctor and patient, cure is very unlikely in this case. Some patients set out to deliberately deceive their physicians for gain [Sneddon and Sneddon, 1975; Sneddon, 1977].

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