A female in her forties presented with 1-month history of recurrent painful ulceration over left upper limb. The patient reported that these lesions started as black-colored plaques followed by ulceration. Her comorbidities included Hepatitis C (treated), Type 2 Diabetes Mellitus (poorly controlled), tobacco addiction and she had also been prescribed Escitalopram 10 mg per day for depression, which she had been taking irregularly. She seemed indifferent about her lesions and had been referred repeatedly to dermatologists by her internist. She had been previously treated as pyoderma with multiple courses of antibiotics. She vehemently denied inflicting the lesions on herself. Clinical examination revealed multiple bizarre-shaped ulcers with reddish-brown crusting, horizontally placed, variable in size and stages ranging from new lesions to scarring confined to flexural aspect of only one arm [Figures 1 and 2]. Based on bizarre morphology, inability of patient to explain the evolution of lesions, confinement of lesions to accessible sites, no discernable rational motive and presence of psychiatric comorbidity, a diagnosis of dermatitis artefacta was considered and she was referred to psychiatry department for detailed psychiatric and mental status examination, which revealed a low affect. She fulfilled the DSM-5 criteria for factitious disorders: (i) falsification of physical signs and symptoms, (ii) presenting herself as injured, (iii) absence of obvious external reward, and (iv) no other psychiatric conditions that would better explain her symptoms. Her husband was ten years elder to her and the constant domestic strife resulted in her dissatisfaction from marital life. Marital disharmony along with a depressed cognition might have resulted in internal conflicts, and producing skin lesions might be her way of resolving them.

Dermatitis artefacta, also known as factitial dermatitis, is a psychocutaneous disorder which falls under the category of somatic symptom and related disorders under DSM-5.\(^1\) It is characterized by self-inflicted cutaneous lesions that patient denies any role in creating. The reason for inflicting the lesions is to satisfy a psychological need of which the patient is not consciously aware. Lack of straightforward history, deception by patient and highly variable presentation makes the diagnosis difficult. Most patients are young females, although it can affect all ages and both sexes.\(^2\) Depression, as seen in our case, is one of the most common comorbidities associated with DA.\(^3,4\) Other

Figure 1: Lesions in various stages of evolution confined to left upper limb

Figure 2: Close-up view showing active, crusted and healed lesions

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associated psychiatric comorbidities include borderline personality disorder, dissociative disorder, anxiety and substance abuse. The disease differs from malingering as self-inflicted lesions are not for conscious gain and from non-suicidal self-injury, as patient denies any role in producing the lesions. Management requires wound care in early stages along with a supportive environment, while psychological aspects can be addressed at follow up after establishment of comfortable doctor-patient relationship and this forms the pillar of patient management. Detailed psychiatric evaluation is warranted for severe self-mutilation and for management of any associated psychiatric illness. The course is chronic, waxing and waning with changing circumstances in patient’s life.

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Conflicts of interest
There are no conflicts of interest.

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