

OUR EXPERIENCE IN THE DIAGNOSIS AND MANAGEMENT OF PSYCHOCUTANEOUS DISORDERS IN A TERTIARY CARE CENTER IN ALBANIA.

Migena Vargu^{1,2}, Sabina Dedej¹, Eriselda Kurushi^{2,3}, Anxhela Nisi¹, Samuele Vargu², Petrit Vargu²

¹Department of Dermatology, University Hospital Center “Mother Teresa”, Tirana, Albania

²Faculty of Medicine, University of Medicine, Tirana, Albania

³Department of Pathology, University Hospital Center “Mother Teresa”, Tirana, Albania

Corresponding Email: mvargu@yahoo.com

ABSTRACT

Background: Psychocutaneous disorders represent a complex interaction between dermatology and psychiatry and often pose significant diagnostic and therapeutic challenges. Increasing evidence from psychoneuroimmunology has strengthened the understanding of the bidirectional relationship between the skin and the psyche. Dermatologists are frequently the first physicians consulted by these patients, making early recognition and multidisciplinary management essential.

Case Presentation: We present a case series of seven patients diagnosed with primary psychocutaneous disorders, including dermatitis artifacts, delusional parasitosis, neurotic excoriations, and trichotillomania. All patients initially presented to a tertiary dermatology unit with atypical or treatment-resistant cutaneous lesions. Clinical evaluation, laboratory investigations, histopathological examination when indicated, and psychiatric consultation were performed in all cases. Several patients demonstrated significant psychosocial stressors, delayed diagnosis, reluctance to accept psychiatric referrals, and repeated unsuccessful dermatologic treatments before definitive evaluation. Management included a multidisciplinary approach combining dermatologic therapy, psychiatric assessment, psychopharmacologic treatment, and supportive care.

Conclusions: Psychocutaneous disorders remain underrecognized in daily dermatologic practice and may mimic a wide spectrum of dermatologic diseases. Early identification, avoidance of unnecessary investigations, supportive physician-patient communication, and close collaboration between dermatologists and psychiatrists are essential for improving patient outcomes and quality of life. Increased awareness and education in psychodermatology may facilitate earlier diagnosis and more appropriate management of these complex patients.

Keywords: psychodermatology, psychocutaneous disorders, self-inflicted dermatoses, delusional parasitosis, trichotillomania, multidisciplinary management.

EKSPERIENCA JONË NË DIAGNOSTIKIMIN DHE MENAXHIMIN E ÇRREGULLIMEVE PSIKOKUTANE NË NJË QENDËR TERCIARE NË SHQIPËRI

ABSTRAKT

Hyrje: Çrregullimet psikokutane përfaqësojnë një ndërveprim kompleks midis dermatologjisë dhe psikiatrisë dhe shpesh paraqesin sfida të rëndësishme diagnostike dhe terapeutike. Evidencat në rritje nga psiko-neuro-imunologjia kanë forcuar kuptimin e lidhjes dy-drejtimëshe midis lëkurës dhe psikikës. Dermatologët shpesh janë mjekët e parë që konsultohen nga këta pacientë, duke e bërë thelbësore njohjen e hershme dhe menaxhimin multidisiplinar.

Paraqitja e rasteve: Ne paraqesim një seri rastesh me shtatë pacientë të diagnostikuar me çrregullime primare psikokutane, përfshirë dermatit artefakt, parasitozë deluzionale, ekskorime neurotike dhe trikotilomani. Të gjithë pacientët u paraqitën fillimisht në një njësi dermatologjike terciare me leziona kutane atipike ose rezistente ndaj trajtimit. U kryen vlerësim klinik, analiza laboratorike, ekzaminim histopatologjik kur ishte i nevojshëm dhe konsultë psikiatrike në të gjitha rastet. Disa pacientë shfaqën stresorë të rëndësishëm psikosocialë, diagnozë të vonuar, hezitim për të pranuar referimin psikiatrik dhe trajtime të përsëritura dermatologjike të pasuksesshme para vlerësimit përfundimtar. Menaxhimi përfshiu një qasje multidisiplinare që kombinoi trajtimin dermatologjik, vlerësimin psikiatrik, trajtimin psikofarmakologjik dhe kujdesin mbështetës.

Përfundime: Çrregullimet psikokutane mbeten të nënvlerësuara në praktikën e përditshme dermatologjike dhe mund të imitojnë një spektër të gjerë dermatozash. Identifikimi i hershëm, shmangia e ekzaminimeve të panevojshme, komunikimi mbështetës mjek-pacient dhe bashkëpunimi i ngushtë midis dermatologëve dhe psikiatërve janë thelbësore për përmirësimin e rezultateve dhe cilësisë së jetës së pacientëve. Rritja e ndërgjegjësimit dhe edukimit në psikodermatologji mund të lehtësojë diagnozën e hershme dhe menaxhimin më të përshtatshëm të këtyre pacientëve kompleksë.

Fjalë kyçe: psikodermatologji, çrregullime psikokutane, dermatoza të vetë-shkaktuara, parasitozë deluzionale, trikotilomani, menaxhim multidisiplinar

INTRODUCTION

Psychodermatology represents the interface between dermatology and psychiatry and encompasses the interaction between the skin and the mind (1). Both the skin and the central nervous system originate from the embryonic ectoderm, which partially explains their close biological relationship (1,2). Recent advances in psychoneuroimmunology have demonstrated that psychological stress, immune dysregulation, and neuroendocrine alterations contribute significantly to the pathogenesis of several dermatologic conditions (3).

Psychiatric comorbidities are estimated to affect approximately 30-40% of dermatology outpatients, highlighting the importance of psychological assessment in dermatologic practice. Despite this high prevalence, psychocutaneous disorders remain underdiagnosed and

are frequently associated with delayed recognition, repeated consultations, unnecessary investigations, and significant impairment in quality of life (4,5).

Many studies have demonstrated substantial knowledge gaps among dermatologists in recognizing and managing psychocutaneous disorders (6,7). During recent years, our department has devoted greater attention to the multidisciplinary evaluation of these patients. In this article, we present seven cases of psychocutaneous disorders managed in a tertiary dermatology center in Albania and discuss the diagnostic and therapeutic challenges encountered in routine clinical practice.

MATERIALS AND METHODS

This case series includes seven patients who were initially presented to the dermatology department of a tertiary care center. A detailed dermatologic examination was performed in all patients, followed by appropriate laboratory investigations, imaging studies, histopathological examination when indicated, and psychiatric consultation. Clinical, psychological, and social factors associated with disease presentation and management were evaluated retrospectively.

Case 1

A 73-year-old male presented to the dermatology clinic accompanied by his daughter because of multiple painful ulcerative lesions involving the scalp, trunk, and extremities associated with burning sensation and severe pruritus. Symptoms had begun approximately 18 months earlier and reportedly worsened after the diagnosis and subsequent death of his wife from malignancy. The patient was living alone. Dermatologic examination revealed multiple round-to-oval ulcerations with sharply demarcated borders, clean bases, surrounding erythema, excoriations, scars, and post-inflammatory hyperpigmentation. The lesions were distributed in atypical, easily accessible areas (Fig. 1, 2). Laboratory and imaging investigations were unremarkable. Bacteriological culture revealed *Escherichia coli*, while histopathologic examination showed nonspecific findings. During psychiatric evaluation, the patient reported severe insomnia with only 3-4 hours of sleep per night. Detailed anamnesis ultimately revealed self-inflicted lesions caused by burning the skin with matches, partially admitted after persistent psychiatric interviewing. Treatment included escitalopram 20 mg daily, lorazepam 1.25 mg at night, topical wound care, and antibacterial therapy.



Figure 1. Case 1- Bizarre ulcerations of varying sizes on the arm.



Figure 2. Case 1- Multiple scars and ulcerations on the back.

Case 2

A 68-year-old female presented with generalized pruritus involving the scalp, face, and body associated with insomnia for approximately six months. She reported that symptoms began after an insect bite near the right eyebrow and described a persistent sensation of living organisms moving beneath the skin (Fig.3). Medical history included hypertension, cardiac arrhythmia, and varicose veins. Dermatologic examination demonstrated only a few erythematous papules with mild scaling. Laboratory and imaging studies were normal. Psychiatric consultation suggested a somatic-type delusional disorder consistent with delusional parasitosis. Treatment with fluvoxamine 100 mg daily and lorazepam was initiated.



Figure 3. Case 2- Erythematous papules below the right eyebrow (red arrow)

Case 3

A 10-year-old girl presented with severe generalized pruritus predominantly affecting the trunk and extremities for six months, with nocturnal exacerbation. Dermatologic examination revealed multiple bilateral papulonodular lesions with central erosions, excoriations, and post-inflammatory hyperpigmentation (Fig.4). Laboratory investigations, imaging studies, and skin biopsy were nonspecific. Psychiatric evaluation identified anxiety symptoms and compulsive behaviors associated with excessive fear of microbes and disease contamination. Short-term treatment with phenibut 250 mg was recommended, together with psychological follow-up.



Figure 4. Case 3- Hyperpigmented nodules with fine central scaling on the leg.

Case 4

A 63-year-old woman presented with pruritic papular lesions involving the chest and upper extremities associated with intense scalp pruritus. She reported chronic insomnia and had been living alone since the death of her husband six years earlier. Dermatologic examination demonstrated brownish-red papules with superficial erosions, serohemorrhagic crusts, and post-inflammatory hyperpigmentation (Fig.5). Histopathologic examination revealed chronic eczema with marked ulceration. Based on the clinical presentation and psychiatric assessment, neurotic excoriations were diagnosed. The patient received topical dermatologic therapy and psychiatric follow-up.



Figure 5. Case 4- Hyperpigmentation on the back and some excoriations

Case 5

A female patient presented with ulcerative lesions involving exposed areas of the face and accessible parts of the extremities. The lesions had irregular borders and atypical distribution. She persistently reported parasite infestation and repeatedly manipulated the lesions to remove them (Fig.6). Psychiatric consultation confirmed the diagnosis of delusional parasitosis.



Figure 6. Case 5- Excoriations and ulcerations of the face secondary to repetitive skin picking.

Case 6

A female patient presented with complaints of hair loss and brought tufts of removed hair to the consultation. Neither the patient nor her mother initially accepted a self-induced cause. No pruritus or burning sensation preceded the onset of alopecia. Examination of the scalp revealed a large patch of alopecia involving the vertex, broken hairs of varying lengths, black dots, and otherwise normal scalp skin (Fig.7). Clinical findings were highly suggestive of trichotillomania, and psychiatric follow-up was recommended.



Figure 7. Case 6- A large area of hair loss with shortened and thinned hairs, varying length hairs, and black dots.

Case 7

A male patient presented with small erosive lesions on the scalp that had initially been treated as folliculitis without clinical improvement. Detailed anamnesis revealed significant anxiety symptoms that worsened following the diagnosis of malignancy in his spouse (Fig. 8). Based on clinical history, lesion morphology, and atypical treatment resistance, the lesions were considered self-inflicted. In addition to dermatologic management, psychiatric consultation was strongly recommended.



Figure 8. Case 7- Irregularly distributed erosive scalp lesions.

DISCUSSION

Psychocutaneous disorders represent a clinically significant but often underrecognized group of conditions at the interface of dermatology and psychiatry. In routine dermatologic practice, these patients rarely present with overt psychiatric complaints; instead, they seek care for persistent, treatment-resistant cutaneous symptoms. This clinical pattern is well documented in the literature, where studies show that a substantial proportion of patients with primary psychocutaneous disorders initially undergo multiple dermatologic consultations and even invasive diagnostic procedures before the correct diagnosis is established (8,9). In our case series, all patients first presented to dermatology services, and psychiatric referral was frequently delayed, reflecting a common global diagnostic pathway characterized by underrecognition and fragmentation of care.

A key observation in our cohort was the strong association between psychosocial stressors and disease onset or exacerbation. Bereavement, social isolation, chronic insomnia, and

anxiety-related symptoms were recurrent across several cases, particularly among elderly patients living alone. This finding aligns with psychoneuroimmunology models, which show that chronic psychological stress can alter hypothalamic–pituitary–adrenal axis activity, immune regulation, and neuroinflammatory pathways, thereby influencing both the perception of pruritus and behavior-related skin damage. Large clinical reviews have similarly reported that stressful life events are common in patients with dermatitis artefacta, neurotic excoriations, and trichotillomania, acting as both triggering and perpetuating factors (10, 11). In our series, stress-related vulnerability was particularly prominent in cases 1, 4, and 7, where recent bereavement or severe emotional distress preceded symptom onset or exacerbation.

Another major diagnostic challenge highlighted by our experience is the marked clinical overlap between psychocutaneous disorders and common inflammatory or infectious dermatoses. Patients often present with nonspecific lesions such as erosions, excoriations, nodules, or ulcerations, which mimic prurigo nodularis, chronic eczema, folliculitis, or even infectious processes. As described in prior dermatologic studies, atypical lesion morphology, geometrical or accessible distribution, and discordance between clinical findings and reported symptom severity are important diagnostic clues suggesting a psychogenic origin (12,13). In our cases, repeated negative laboratory results and nonspecific histopathology further contributed to diagnostic uncertainty, often prolonging the time to psychiatric evaluation.

A particularly relevant finding in our series was the high rate of prior misdiagnosis and prolonged ineffective dermatologic treatment before psychocutaneous disorders were considered. This is a well-recognized phenomenon in literature, where patients with dermatitis artefacta or delusional parasitosis may undergo repeated antibiotic therapy, topical corticosteroid use, or even surgical interventions without clinical improvement. Such delays not only increase healthcare utilization but may also reinforce maladaptive illness behavior and reduce patient trust in medical professionals. Jafferany et al. have shown that early recognition and reframing of the diagnosis in a non-confrontational manner significantly improve patient adherence and reduce unnecessary interventions (14).

Communication and the physician–patient relationship emerged as a central determinant of clinical outcome in our series. Many patients initially denied self-inflicted behavior or resisted psychiatric referral, which is consistent with known poor insight in disorders such as delusional parasitosis and trichotillomania. Literature emphasizes that confrontation often leads to therapeutic rupture, whereas a neutral, empathetic, and non-judgmental approach facilitates gradual acceptance of psychiatric involvement (15). In our experience, supportive communication strategies were essential in achieving partial insight and treatment adherence, particularly in cases involving somatic delusions or compulsive behaviors.

The importance of multidisciplinary management was strongly evident across all cases. Combined dermatologic and psychiatric intervention allowed for more accurate diagnosis, reduced unnecessary investigations, and improved therapeutic planning. Current evidence supports integrated psychodermatology models in which cognitive behavioral therapy, selective serotonin reuptake inhibitors, and habit reversal techniques are used alongside dermatologic care. Such integrated approaches have been shown to improve symptom control, reduce relapse rates, and enhance quality of life, particularly in trichotillomania and neurotic excoriations (16,17)

Finally, our case series underscores that psychocutaneous disorders should be actively considered in patients with chronic, atypical, or treatment-resistant dermatoses, especially when lesions are in accessible body areas and when clinical findings do not fully explain symptom severity. Early recognition is critical not only to prevent chronic skin damage but also to reduce psychological distress, social impairment, and healthcare burden. Increasing awareness among dermatologists remains essential, particularly in settings where structured psychodermatology services are still limited.

The main limitation of this report is the small sample size and retrospective descriptive design.

CONCLUSIONS

Our case series highlights the importance of careful clinical observation, detailed psychosocial assessment, recognition of atypical lesion morphology, close collaboration between dermatologists and psychiatrists, and maintenance of a supportive, nonjudgmental physician-patient relationship. Early diagnosis may help avoid unnecessary investigations, prolonged ineffective treatments, repeated consultations, and additional psychological distress. Greater awareness and education in psychodermatology are needed, particularly in countries where this field remains insufficiently recognized in routine clinical practice.

Patient Consent: Written informed consent was obtained from all patients (or their legal guardians) for publication of the clinical data and identifiable clinical images.

Conflict of Interest: The authors declare no conflict of interest.

Author Contributions: All authors contributed to the preparation of the manuscript and approved the final version.

REFERENCES

1. Ferreira BR, Aguirre CC, Rapoport-Hubschman N, et al. The skin-brain connection and pleasant touch as supportive care for psychocutaneous disorders. *Skin Health Dis.* 2023;4(1):e310. doi:10.1002/ski2.310
2. Rewane A, Munakomi S. Embryology, Central Nervous System, Malformations. In: StatPearls. Treasure Island (FL): StatPearls Publishing; March 6, 2023.
3. Bower JE, Kuhlman KR. Psychoneuroimmunology: An Introduction to Immune-to-Brain Communication and Its Implications for Clinical Psychology. *Annu Rev Clin Psychol.* 2023;19:331-359. doi:10.1146/annurev-clinpsy-080621-045153
4. Nowak DA, Wong SM. DSM-5 Update in Psychodermatology. *Skin Therapy Lett.* 2016;21(3):4-7.
5. Tan IJ, Mitelman A, Jafferany M. Psychocutaneous Disorders in Pediatric and Adolescent Populations: A Narrative Review. *Am J Clin Dermatol.* 2026;27(3):493-502. doi:10.1007/s40257-026-01026-1

6. Christensen RE, Jafferany M. Unmet Needs in Psychodermatology: A Narrative Review. *CNS Drugs*. 2024;38(3):193-204. doi:10.1007/s40263-024-01068-1
7. Tan IJ, Katamanin OM, Barry J, Jafferany M. Psychocutaneous medicine: current global understanding and imperatives for continuing medical education and training opportunities. A systematic review. *Clin Exp Dermatol*. 2025;50(4):740-746. doi:10.1093/ced/llae484
8. Criton VJS, Tharakan AL, et al. Beyond the surface: exploring the mind-skin dynamics of psychodermatology. *Med Res Arch*. 2024;12(11). doi:10.18103/mra.v12i11.6006
9. Harth W, Hermes B. Psychosomatic disturbances and cosmetic surgery. *J Dtsch Dermatol Ges*. 2007;5(9):736-743. doi:10.1111/j.1610-0387.2007.06293.x
10. Evers A.W.M., van Beugen S. How stress affects the skin: from designs to mechanisms. *Br J Dermatol*. 2021;185(1):12–13. doi: 10.1111/bjd.20397.
11. Zhang H., Wang M., Zhao X., Wang Y., Chen X., Su J. Role of stress in skin diseases: a neuroendocrine-immune interaction view. *Brain Behav Immun*. 2024;116:286–302. doi: 10.1016/j.bbi.2023.12.005
12. Torales J, Malvido K, Vázquez MA, et al. Dermatitis Artefacta: A Practical Guide for Diagnosis and Management. *Acta Dermatovenerol Croat*. 2023;31(1):17-23.
13. Mohandas P, Bewley A, Taylor R. Dermatitis artefacta and artefactual skin disease: the need for a psychodermatology multidisciplinary team to treat a difficult condition. *Br J Dermatol*. 2013;169(3):600-606. doi:10.1111/bjd.12416
14. Jafferany M, Ferreira BR, Abdelmaksoud A, Mkhoyan R. Management of psychocutaneous disorders: A practical approach for dermatologists. *Dermatol Ther*. 2020;33(6):e13969. doi:10.1111/dth.13969
15. Kemperman PMJH, Saradjzade V, Vulink NCC, De Rie MA, Voskes Y. Ethical and Communicative Challenges in Informing Patients with Delusional Infestation: Insights from Moral Case Deliberation. *Acta Derm Venereol*. 2025;105:adv43511. doi:10.2340/actadv.v105.43511
16. Katamanin O, Sharifi S, Jafferany M. Psychopharmacology in Dermatology. *Indian Dermatol Online J*. 2026;17(2):178-184. doi:10.4103/idoj.idoj_186_25
17. Sekhon S, Kroumpouzou G, Koo J. Psychopharmacology. *G Ital Dermatol Venereol*. 2018;153(4):549-556. doi:10.23736/S0392-0488.18.05978-3