

ACTAS Derma-Sifiliográficas

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CASE FOR DIAGNOSIS

Nasal Ulceration

Ulceración nasal

Medical History

A 64-year-old woman presented with a painless lesion that had appeared 3 years earlier on the left ala nasi and had not healed spontaneously. The patient did not recall any injury and reported no local sensory alterations; she also denied any manipulation of the lesion. She had a history of ductal carcinoma of the breast treated with surgery, chemotherapy, and radiotherapy, with no recurrence to date; tetraventricular hydrocephalus; and an Arnold Chiari malformation associated with hydrosyringomyelia of C2 to D4, with paresis of the left upper limb as the only secondary symptom. She had also been seen in the psychiatric department for depression.

Physical Examination

In the left nasolabial sulcus there was noninfiltrated area of erythema and scaling around an ulcer that was enlarging centrifugally and had excavated through part of the left ala nasi. The surface was blood-stained and had an adherent flat scab (Figure 1).

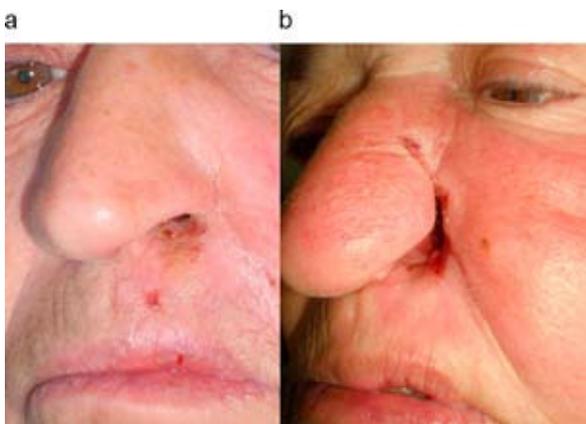


Figure 1

Histopathology

Two skin biopsies excluded malignancy and other possible diseases. In the first biopsy the findings were compatible with lichen simplex; the second biopsy showed superficial ulceration with acanthosis and a perivascular inflammatory infiltrate (Figures 2 and 3).

Additional Tests

Examination by the neurology department found no alteration of the trigeminal nerve and no other signs suggestive of a trigeminal trophic syndrome.



Figure 2 Hematoxylin-eosin, original magnification $\times 40$.

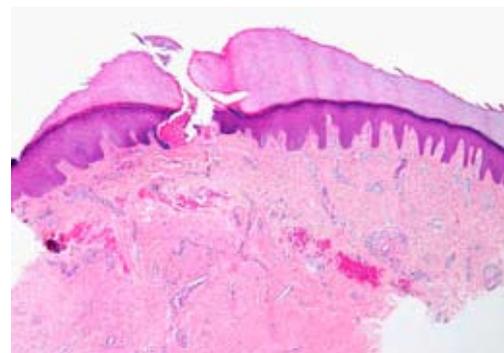


Figure 3 Hematoxylin-eosin, original magnification $\times 100$.

What Was Your Diagnosis?

Diagnosis

Dermatitis artefacta.

Clinical Course and Treatment

Conservative treatment with a prosthesis was elected. The patient was lost to follow-up.

Discussion

Trigeminal trophic syndrome and dermatitis artefacta are 2 rare causes of self-induced nasal ulceration.¹ They must be distinguished from other, more common causes, particularly tumors, infection, and granulomatous diseases.² Skin biopsy, laboratory tests, and culture are sufficient for a correct diagnosis.

Trigeminal trophic syndrome is characterized by the triad of anesthesia of the trigeminal nerve, paresthesias, and ulceration of the ala nasi. The ulcer is painless, with a typical crescent shape and a scab, and does not affect the tip of the nose. The lesions are self-induced and the patients acknowledge this. The paresthesias and anesthesia give rise to a feeling of nasal congestion and lead to continuous touching.¹⁻³ In two thirds of cases, the damage to the nerve is iatrogenic, due to its ablation as a treatment for neuralgia (33%), or secondary to a cerebrovascular accident (33%).³ Other causes include syringobulbia.³ It is most common in elderly women and diagnosis is clinical. This disorder tends to become chronic and treatment is often unsatisfactory. Patient education and measures to protect the wound are the most important aspects.¹⁻³

Dermatitis artefacta is included in the spectrum of the factitious disorders, defined as simulated or self-inflicted diseases, in which the symptoms are provoked by the individual with the aim of becoming a patient. It is usually observed in young women, who typically do not acknowledge their actions. The majority of patients have a borderline personality disorder, although this diagnosis has also been associated with many other psychological conditions, including depression.^{4,5} The skin lesions are highly varied and nonspecific, and the face is involved in around 50% of cases.⁶ The diagnosis is usually reached by exclusion. The prognosis is variable and the disorder can persist for years. Psychotherapeutic treatment is required

and is based on a good physician-patient relationship. Psychotropic drugs may be used.^{5,6}

Our patient had a lesion highly suggestive of trigeminal trophic syndrome, but she did not describe the typical neurological symptoms. Physical examination of the trigeminal nerve was normal, and there was no history of damage to the nerve. Syringobulbia is described as a possible cause. However, in our patient the lesion was lower (C2 to D4), at a location which could not damage the trigeminal nerve. The patient also had a history of depression and denied causing the lesion. Based on these observations and on the nonspecific findings of the biopsies, we reached a diagnosis of dermatitis artefacta by exclusion and decided on conservative treatment.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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