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Psychotropic Drugs in Dermatology☆

FR-Utilización de psicofármacos en dermatología

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In daily dermatology practice it is not uncommon to encounter psychiatric disturbances that can present as psychodermatoses or as psychological complications of chronic diseases. Delusional parasitosis, psychogenic pruritus, dermatitis artefacta, trichotillomania, and the somatoform disorders belong to the first group, while the archetypal diseases in the second group are psoriasis, atopy, and acne. These patients are usually unwilling to be referred to a psychiatrist and, if referral is achieved, the therapeutic alliance achieved in the clinical interview is lost in many cases. It is therefore necessary for the dermatologist to have a basic understanding of the psychotropic drugs in order to initiate appropriate treatment.[1,2]

The psychotropic drugs most frequently prescribed in daily clinical practice are the antidepressants, the benzodiazepines, and the antipsychotics (Table 1). Of these 3 groups, the antidepressants—specifically, the serotonin reuptake inhibitors—are the drugs most commonly employed in dermatology consultations. These drugs are safe and have few side effects, the most important of which are gastrointestinal disturbances, insomnia, and sexual dysfunction. They are used particularly in cases of neurotic excoriation, dysmorphophobia, trichotillomania, and chronic pruritus. They must be administered for a minimum of 4 to 6 weeks before the effects become evident, and treatment must be continued for several months. Drug withdrawal must be gradual to avoid recurrence or withdrawal symptoms (anxiety, nausea, diaphoresis, and others).

Other antidepressants used in dermatology are the tricyclic (doxepine and amitriptyline) and the tetracyclic (mirtazapine) antidepressants. Both types block serotonin, norepinephrine, and dopamine reuptake, whilst also acting as histaminergic, cholinergic, and α-adrenergic receptor antagonists. These drugs are useful in neurotic excoriation, generalized pruritus, and chronic urticaria. Amitriptyline is used in the treatment of postherpetic neuralgia. The main side effects are sedation, blurred vision, dryness of the mouth, urinary retention, constipation, and increased intraocular pressure. Amitriptyline can produce cardiovascular effects, including arrhythmias and prolongation of the QT interval.

The benzodiazepines act mainly as anxiolytics and sedatives and, in dermatology, they are therefore mainly employed to minimize anxiety secondary to a dermatologic

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Table 1 Main Psychotropic Drugs Used in Dermatology.

Drug	Classification	FDA Indications	Dermatologic Indication	Side Effects	Starting Dose	Maintenance Dose
Antidepressants						
Fluoxetine	SSRI	OCD, MD, EBD, agoraphobia	Neurotic excoriation Dysmorphophobia Trichotillomania Chronic pruritus	Gastrointestinal effects Insomnia Sexual dysfunction No weight gain, except with paroxetine	20 mg/d	20-60 mg/d
Paroxetine	SSRI	OCD, MD, GAD, PTSD, agoraphobia, social phobia			20 mg/d	20-50 mg/d
Sertraline	SSRI	OCD, MD, PTSD, agoraphobia, social phobia			50 mg/d	50-200 mg/d
Citalopram	SSRI	MD			20 mg/d	20-60 mg/d
Escitalopram	SSRI	MD, GAD			10 mg/d	10-20 mg/d
Fluvoxamine	SSRI	OCD, social phobia			50 mg at night	100-300 mg at night
Amitriptyline	TCA	MD	Neurotic excoriation Generalized pruritus Chronic urticaria Postherpetic neuralgia with amitriptyline	Anticholinergic effects Sedation Increased IOP Prolongation QT interval Weight gain	25 mg at night	25-75 mg at night
Doxepine	TCA	MD, GAD, insomnia, chronic pruritus			25 mg at night	25-100 mg
Mirtazapine	TeCA	MD			15 mg at night	15-45 mg
Anxiolytics						
Alprazolam	Short-acting BZ	GAD, agoraphobia	Anxiety states related to chronic disease Short-term use (7-10 d)	Tolerance Dependence Sedation Anterograde amnesia Paradoxical reactions	0.125-0.250 mg up to 4 times/d	0.25-0.5 mg up to 3 times/d
Lorazepam	Intermediate acting BZ	Anxiety, insomnia			1-2 mg up to 2-3 times/d	1-2 mg up to 2-3 times/d, maximum dose 4 mg/d
Clorazepate dipotassium	Long-acting BZ	GAD, anxiety			10-45 mg up to 2-3 times/d	10-45 mg up to 2-3 times/d, Maximum dose 90 mg/d
Antipsychotics						
Pimozide	1st generation	Gilles de la Tourette syndrome	Delusional parasitosis	Extrapyramidal symptoms Anticholinergic effects Increased PRL Prolongation QT interval	0.5-1 mg/d	1-6 mg/d

Abbreviations: BZ, benzodiazepine; EBD, eating behavior disorder; FDA, Food and Drug Administration of the United States; GAD, generalized anxiety disorder; IOP, intraocular pressure; MD, major depression; OCD, obsessive-compulsive disorder; PTSD, posttraumatic stress disorder; SSRI, selective serotonin reuptake inhibitor; TCA, Tricyclic antidepressant; TeCA, Tetracyclic antidepressant.

disease. They should only be used for short periods as they can induce tolerance and dependence.

The antipsychotics are a group of drugs that are difficult for dermatologists to manage. The most widely used is pimozide, employed as first-line treatment in delusional parasitosis. Remission is achieved in 50% of cases with doses of 2 to 4 mg/d.[2–4] Pimozide is a dopamine receptor antagonist, and its side effects include extrapyramidal symptoms, blurred vision, orthostatic hypotension, constipation, and urinary retention. It is important to remember that pimozide can stimulate prolactin secretion and prolong the QT interval.

In conclusion, the management of the psychocutaneous disorders requires a multidisciplinary approach in the emerging psychosomatic medicine units. Collaboration between dermatologists, psychologists, and psychiatrists will provide integral treatment for the patient. It is important to perform an adequate psychological evaluation and be prepared to initiate treatment with psychotropic drugs when necessary. The dermatologist should therefore be aware of the main psychotropic drugs.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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