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Case Report

Atopic dermatitis, a psycho-dermatological disease needs attention beyond pharmacotherapy: A case report

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ABSTRACT

Atopic dermatitis is a chronic inflammatory skin condition. The condition may cause significant impairment of quality of life because of severe symptoms. Stress is known factors for the aggravation of symptoms. Non-pharmacological and pharmacological treatments are important in its management. We report a case of atopic dermatitis successfully managed with additional psychotherapy and counselling after initial ineffective response to pharmacotherapy.

1. Introduction

Many dermatological diseases are chronic in nature. It is known that chronic disease can be a risk factor for mood disturbance. Relation between skin and mind has been proposed since long time. Atopic dermatitis, a chronic dermatological disorder can predispose to anxiety and depression.[1–6] Female preponderance of psychiatric disorder has been reported in patients with atopic dermatitis.[3] Psychological disturbance in such patients can affect course of the disease and adversely affect effectiveness of therapy.[1]

Current guideline recommends psychological and psychosomatic interventions in the management of atopic dermatitis.[7] Dermatologists should perform thorough assessment of psychiatric illness in patients with atopic dermatitis to find out underlying problem and treat it effectively independently or with the help of psychiatrist.

We present a case of atopic dermatitis successfully managed with additional psychotherapy and counselling after initial ineffective response to pharmacotherapy.

2. Case presentation

A 30 year old unmarried female, known case of poliomyelitis of left leg was referred by a general physician for severe itching and lesions on her face, arms, neck and back. She was working in an event management firm. Before presenting she was seen by three dermatologists. Her previous treatment included oral and topical steroids. She had discontinued oral cyclosporine because of no symptom relief. The patient was extremely disappointed with the course of disease and non-responsive treatment. She did not start cyclosporine again despite counselling about the safety of medicine.

She kept getting flare up of lesions with late night work and sweat. Sweating was usually triggered by the hot humid weather. She lived with her mother and brother in her uncle's house. Her father had passed away when she was young. There were disputes in the family regarding property.

She was overweight. Her laboratory examination showed serum cholesterol 224 mg/dl, triglyceride 376 mg/dl, lactate dehydrogenase 226 U/L, erythrocyte sedimentation rate 45 mm/hour and raised eosinophil count. Thyroid stimulating hormone level was 8.75 mIU/L at the time of presentation.

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2.1. Management

All previous medicines were discontinued and the patient was started on prednisolone 5 mg half tablet, tablet amitriptyline 10 mg and desloratidine. A topical betamethasone dipropionate 0.05% cream with a moisturiser was given to apply twice a day. Patient was asked to keep skin moist and use lukewarm water for bathing. She was asked to bathe three times a week only and avoid synthetic clothing which would rub against the eczematous areas.

On the first day of consultation, patient was counselled for 45 minutes with careful listening to complaints and allowing her to talk without interruption. She was given instructions for changing her thought process.

After two weeks follow up, patient reported significant improvement of symptoms. Skin examination at this time showed almost 50 % improvements in the eczematous lesions. Patient seemed perked up and hopeful that she would be able to overcome the situation. Treatment was continued with a gradual tapering of the steroids (topical and oral both). Tablet amitriptyline and counselling was continued.

After one month, steroids were continued to be tapered and topical tacrolimus 0.1 % ointment was started. Counselling was continued. After two months, patient was off biweekly dose of steroids and tacrolimus 0.1% was stepped up for eight months. Counselling was continued.

After nine months, patient was on topical steroids biweekly with tacrolimus biweekly. Levocetirizine 5 mg was given only for 10 days.

After ten months, patient had mild flare, hence dose of levocetirizine increased and continued for 10 days. Rest all treatment was continued along with counselling. After 12 months of follow up, patient had steady improvement in the symptoms and mood. She was asked to take levocetirizine as and when required for symptomatic relief of itching.

After this treatment, since last three years, this patient is visiting occasionally for consultation with mild flare ups. Counselling helped her identify the probable thought related aggravation of itch. Flares are significantly controlled and she is off the high doses of oral and frequent applications of topical steroids.

3. Discussion

Atopic dermatitis is a chronic inflammatory skin disorder. Higher incidence of depression has been reported in severe cases of atopic dermatitis.[8] Moreover, presence of psychological disturbance can adversely affect effectiveness of therapy.[1] For successful outcome of treatment, identification of psychiatric problem is important. In patients with atopic dermatitis, severity of symptom can be related to family stress.[9]

In our case, several clues during clinical history suggested presence of family stress and economic problems. It is significantly important for clinicians to spend sufficient time with patients to understand them entirely. Complete and detailed history of patient can help to identify the trigger for flare. In many cases, emotional stress works as a trigger for symptom flare. In our case, family history suggestive of emotional trauma was picked as trigger for her symptoms. In our case, family related stress was clearly evident from the history. Patients should be given sufficient time for expressing their emotions. In our case, patient was unable to speak her mind to anyone because of family issues. She vented out most of her emotions in the clinic. Effective counselling and pharmacotherapy helped her to get over the symptoms. Clinical acumen of identifying trigger and effectively address it can support the success of treatment of chronic disease associated with psychological disturbance.

Clinicians treating atopic dermatitis should examine the patient thoroughly and evaluate related psychosocial domains. After identifying the relevant trigger, patients should be given psychological and behavioural therapy. Coping strategies for existing triggers should be advised to the patient.[10] Work profile of our patient required overnight shifts which was another trigger for symptoms. She was advised to make changes in her work profile as much as possible. Hot and humid weather was unavoidable because of the inherent conditions of the city. She was asked to bathe three times a week only and avoid synthetic clothing which would rub against the eczematous areas.

After identification of psychological stress, effective counselling to change thought process instead of trying to change to situation can make significant difference. In our case, patient followed the instructions and agreed to identify negative thoughts and follow the prescription. With effective counselling, patient was tapered off from steroids and their potential adverse events.

Overall, as reported in the literature, we agree that psychodermatology involves link between skin and mind. Hence dermatologists should effectively counsel the patients with chronic disorders for better outcomes.[9]

4. Conclusion

In unresponsive cases of atopic dermatitis, attempts should be done to find out trigger for flare ups. Effective counselling plays a significant role in success of overall therapy. Our patient with atopic dermatitis showed significant improvement after prolonged counselling and pharmacotherapy.

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6. Conflict of Interest

The authors declare they have no conflict of interest.

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