Excoriation Disorder, Self-Induced Craniectomy, and the Limitations of Telepsychiatry

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Objectives

- Present a severe case of excoriation disorder complicated by stimulant use.
- Highlight the limitations of telepsychiatry in diagnosing excoriation disorder and other disorders associated with self-injurious behavior.

Case Presentation

A 39-year-old female with MDD, GAD, ADD on stimulants, and OCD with skin-picking behaviors and a medical history of chronic Lyme disease presented with a skull wound.

She was psychiatrically co-managed by a local psychiatric clinic and an out-of-state psychiatrist specializing in chronic Lyme Disease. During telepsychiatry visits, she wore a knit cap to hide her wound. None of the providers was aware of her injuries.

History

- 2002: diagnosed with ADHD in high school; started methylphenidate ER.
- 2007: developed tachycardia from methylphenidate ER. Switched to amphetamine-dextroamphetamine.
- 2010-2015: finished college. Started a job as a nanny. Took intermittent stimulant holidays.
- 2015-2017: developed alcohol use disorder.
- May 2017: entered substance rehab program.
- Fall 2017: developed fatigue, diaphoresis, leg pain; concerned about chronic Lyme.
- Feb 2018: started skin-picking.
- June 2019: diagnosed with chronic Lyme.
- Feb 2022: presented to the hospital.

Hospital Course

Initial Psychiatric Evaluation

- Worsening depression and anxiety since 2017
- Preoccupied with sensation of "hair fibers" under her scalp
- Used both her nails and cuticle nippers to remove pieces of her skull

Physical Examination

5cm wound extending through the skull, with the superior sagittal sinus visible on the surface of the brain.

Imaging

CT Head

- Herniation of the right frontal lobe through the skull
- 2.1 x 2.2 cm hypodensity concerning for subacute infarct

MRI Brain

- Three areas of restricted diffusion with peripheral enhancement concerning for developing abscesses

Imaging (continued)

Figure 1. CT Head – Coronal view

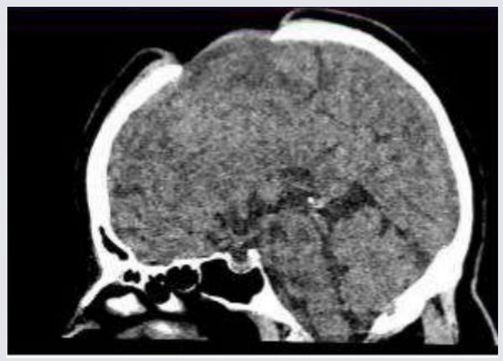

Figure 2. CT Head – Sagittal view

Surgical Interventions

- Serial debridement
- Definitive repair with mesh cranioplasty and thigh flap

Pharmacologic Management

- Admission medications:
  - duloxetine 60mg PO daily
  - gabapentin 300mg PO TID
  - mirtazapine 15mg nightly
  - amphetamine-dextroamphetamine 20mg TID
- Discharge medications:
  - duloxetine 60mg PO daily
  - gabapentin 300mg PO TID
  - escitalopram 30mg PO daily
  - propranolol 10mg qam, 10mg q12pm, and 20mg qhs
  - quetiapine 75mg TID

Hospital Interventions

- Medications adjustments: impulse to pick decreased after stimulants were stopped
- Individual DBT skills
- Coordinated with outpatient psychiatrists. Recommended in-person appointments for post-discharge follow-up

Discussion

- During COVID-19 pandemic telepsychiatry has emerged as a way to expand access to care while minimizing infectious risk.[1]
- One of the most obvious limitations of telepsychiatry is the risk of an incomplete physical exam.[2]
- Specific conditions associated with self-injury such as excoriation disorder may be less appropriate for treatment using telepsychiatry given the risk of worsening self-injury that goes unnoticed.

Conclusion

This case highlights the limitations of telepsychiatry in evaluating life-threatening complications of excoriation disorder and other disorders with self-injurious behavior. Further work needs to be done to develop a standardized physical exam for use in the telepsychiatry setting.

References

1.Shore JH, Schneck CD and Mishkind MC. Telepsychiatry and the Coronavirus Disease 2019 Pandemic—Current and Future Outcomes of the Rapid Virtualization of Psychiatric Care. *JAMA Psychiatry*. 2020; 77: 1211-2.
2.Reeves JJ, Ayers JW and Longhurst CA. Telehealth in the COVID-19 era: a balancing act to avoid harm. *Journal of Medical Internet Research*. 2021; 23: e24785.