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THE RECURRENCE OF SKIN DERMATOSIS IN PATIENTS WITH ESSENTIAL MENTAL DISORDERS

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Abstract:
Objective: *To decide on the recurrence of skin dermatosis in patients with essential mental disorders.*
Methods and Results: *This cross-sectional survey was conducted in Fountain House, Lahore, which is a tertiary consideration community for mental patients with indoor and outdoor offices. Our current research was conducted at Services Hospital, Lahore from May 2017 to April 2018. All admitted mental patients (298) were included in the study. They were fully inspected for any skin dermatosis. Of the 298, skin problems were observed in 174 (59.6%) patients, 90 (61.7%) males and 59 (38.6%) females. The most widely recognized essential mental disorders were schizophrenia (47.5%) pursued by substance abuse patients (27.6%), bipolar disorder (15.2%), discouragement and psychosis (9.3% each). 3.8% of patients were hyperactive. Overall, 17.4% of patients had infectious dermatoses and the remainder had non-infectious dermatoses. A high frequency of xerosis and summarized pruritus was observed in both males and females. Of the non-infectious dermatoses, 11.2% had skin inflammation,7.3% had rash, 6% had melasma, 5.2% had palmoplantar keratoderma, 4.3% had hypochondriac abrasions, 4.3% had artificial dermatitis, 3.8% had trichotillomania, 3.2% had miliaria and 2.5% had ichthyosis.*
Conclusion: *A high incidence of contagious diseases, mostly tinea versicolor and onychomycoses, has been found in patients with essential mental disorders.*
Keywords: *Psychiatric patients, skin disorders.*

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INTRODUCTION:

The link between brain and skin research is undeniable [1]. Stress, discomfort and grief have been found to add to the severity of previous skin conditions such as rashes, psoriasis or atopic dermatitis, or to cause the onset of so-called psycho-skin changes that can be distressing and disappointing for clinicians and patients alike [2-3]. Psychosocial components should be considered a primary concern when dealing with dermatologic issues, compared with patients who have a core specialist question, dermatologic issues must be monitored effectively. There is not a great deal of distributed information on the recurrence of dermatoses in these patients [4-5].

METHODOLOGY:

This cross-sectional survey was conducted in Fountain House, Lahore, which is a tertiary consideration community for mental patients with indoor and outdoor offices. Our current research was conducted at Services Hospital, Lahore from May 2017 to April 2018. As part of this investigation, each of the patients conceded in the Wellspring House, Lahore for their essential mental condition has been enlisted. A thorough dermatological evaluation was done on all patients. Necessary examinations, such as scraping for parasites and biopsy, were performed as required. Data were correctly reported on a proforma and incorporated.

RESULTS:

Out of 298 patients, skin problems were observed in 174 (59.7%) patients with essential mental disorders. Of these, 90 (61.7%) were male and 59 (40.5%) were female. The most common essential mental disorders were schizophrenia in 48% of patients and substance abuse in 27.6% of patients. Bipolar disorders were observed in 14% of patients, melancholia and psychosis were present in 9.3% and 3.8% of patients individually (Table 1). Overall, 16.3% of patients had infectious dermatoses and the remainder had non-infectious skin problems. A high rate of pruritus (26%) and xerosis (18%) was observed in both males and females. Non-infectious dermatoses included dermatitis (11.2%), skin inflammation (7.2%), melasma (6%), palm keratoderma (5.2%), miliaria (3.2%), and ichthyosis (2.4%) [Table 2]. Of the disorders, 4.3% had masochistic abrasions. Artefacta dermatitis and trichotillomania were observed in 4.3% and 3.8% of patients individually (Table 2). Among the infectious dermatoses, a higher rate of dermatophyte contamination (7.2%) was noted on examination. Among the infectious contaminations, onychomycosis, pityriasis versicolor and tinea corporis were observed for the most part. Parasitic invasions were observed in 8% of patients in the examination group. Of these, scabies was available in 6% and heady pediculosis in 3%.

Table 1: Distribution of common primary psychiatric disorders (n=298).

Psychiatric disorders	Male	Female	Total
Schizophrenia	1%	2.74%	3.74%
Addiction	28%	21%	49%
Bipolar disorder	7.1%	21%	28.7%
Depression	8%	7%	15%
Psychosis	6.18%	4%	10.18%

Table 2: Supply of skin illness in research set (n=174).

Skin disorders	%
Infective dermatoses	
Pediculosis capitis	15 (9.0)
Dermatophytic infections	10 (6.1)
Scabies	8 (5.0)
Non-infective dermatoses	
Pruritus	17 (10.1)
Xerosis	8 (5.0)
Eczema	30 (17.0)
Acne	10 (6.2)
Melasma	9 (5.0)
Palmoplantar keratoderma	3 (2.1)
Miliaria	2 (1.3)
Ichthyosis	2 (1.3)

DISCUSSION:

As early as the beginning of this century, there was agreement that the skin of the vast majority of patients suffering from psychological illnesses was undesirable and suffered directly or indirectly. Lynch 1948 said that specific skin signs give the impression of proof of a psychobiological imbalance. Our review was to see the appearance of skin lesions in a rationally ill population and to assess skin diseases related to the unconventional infectious and dietary hazards of institutional life [6]. The schizophrenia and drug-dependent patients in the present survey, is not consistent with other studies, in which gloom and nervousness were the most well-known key issue. This could be explained by the way in which admitted patients participated in our survey and by the fact that nervousness and sadness are mostly treated on an outpatient basis [7]. Inflammation of the skin and melisma were observed mostly in mental patients, acne exorcises was particularly found in patients suffering from schizophrenia. Excoriated skin breakdown has been reported in phobic states, discouragement and hallucinatory disorders. Among the infectious dermatoses, fungal infections were all the more frequent as they were probably due to the moist state of our region [8]. Superficial contagious diseases were observed more in male than female mental patients; the cleanliness of female patients was far superior to that of male patients; thus, the increase in parasitic contaminations in men could be attributed to poor individual cleanliness and neglect. In our survey, the majority of patients with contagious contaminations were schizophrenics [9]. Hallucinogenic parasitosis influences both sexes similarly before the age of 510 years and is associated with schizophrenia, neurotic states, bipolar problems, sadness, malaise and obsessive states. In our investigation, fantasy parasitosis was found in schizophrenic patients and this is virtually identical to the examination conducted by Kuruvilla et al. in India. Because of its juvenile nature, artifact dermatitis is usually found in young people, and in this patient the others must be considered. Artifact dermatitis has been observed most consistently in women and in early adult gatherings. Our investigation revealed a similar age and gender appropriateness [10]. Artifact dermatitis has been found in patients with drug addiction and schizophrenia. Despite the fact that patients with trichotillomania present regularly to dermatologists, analysis and treatment are in the field of psychiatry. Graber and Arndt11 found that 8% of patients associated pulling out their hair with an opportunity for continued disruption. It was noted that 27% of patients had undergone a medical procedure or injury, and 47% detailed a related distress opportunity.

CONCLUSION:

Trichotillomania has a bimodal time of introduction and 46% of patients denied that their alopecia was initiated without someone else's input. In our survey, trichotillomania was observed in 4.3% of patients with a female prevalence and these patients were experiencing extreme grief. Psychotic abrasions were observed in 4.3% of patients. The most widely recognized coincidental mental conditions were misery and tension problems. The association between psychiatry and dermatology is developing and a broader understanding of these disturbing issues is needed. Gradually planned case control examinations are needed to provide more knowledge in this fascinating field and to record and prove the consequences of our examination.

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