



## Letter to the Editor

### Edited by Stephen P. Stone, MD

#### Comment to the contribution, “Assessment and treatment of trichotillomania (hair pulling disorder) and excoriation (skin picking) disorder,” by Jones and colleagues



We have read with interest the contribution by Jones and colleagues<sup>1</sup> entitled, “Assessment and treatment of trichotillomania (hair pulling disorder) and excoriation (skin picking) disorder,” recently published in *Clinics in Dermatology*. In particular, we have focused our attention on the paragraphs dedicated to skin picking, a body-focused repetitive behavior disorder that is characterized by excessive scratching or picking of normal or slightly irregular skin and affecting up to 5% of the general population.<sup>2</sup> Despite the clinical effects of skin picking, which is a burden not only of psychologic distress and social embarrassment but is also associated with infectious and dermatologic complications including acne, there are no clear therapeutic guidelines.

In their paper, Jones et al<sup>1</sup> have reviewed the literature of the pharmacologic and nonpharmacologic treatment options for this skin picking disorder and have reported two patients with body-focused repetitive behavior disorders. In particular, one patient was a young woman with an obsessive-compulsive disorder including hand-washing compulsions that developed the compulsion to expel any purulent tissue by pulling out her hair. Her anxiety and depression were successfully treated with fluoxetine, N-acetylcysteine, and psychologic support. Her picking and pulling compulsions were so severe that the option to add olanzapine was considered but not carried out to avoid its side effects.

Although meta-analysis studies<sup>3</sup> and uncontrolled open-label trials<sup>4</sup> have reported no conclusive results for the efficacy of selective serotonin reuptake inhibitors (SSRIs) in skin picking, patients suffering from this disorder could benefit from antidepressants, considering the high frequency of comorbidities with other psychiatric disturbances (ie, depression or obsessive-compulsive spectrum disorders) that could exacerbate picking manifestations.<sup>5</sup>

We previously described a 59-year-old woman suffering from a severe skin-picking behavior of infected lesions around her lips, cheeks, chin, and nose. She had the urge to pick many

times during the day, representing distress and frustration. Apart from the skin-picking disorder, she presented with a never-treated obsessive-compulsive personality disorder. We initially chose to treat our patient with fluvoxamine and oxcarbazepine with only partial benefit. Then, we suspended oxcarbazepine and added a low dosage of haloperidol that led to a full recovery after 10 weeks.<sup>6</sup>

Even if the literature on the use of antipsychotics in the treatment of skin picking is limited, several reports have supported the use of both first- and second-generation antipsychotics in the treatment of this excoriation disorder, particularly in more severe cases.<sup>7</sup> The benefit of these drugs should not be considered as “class-effect.” In fact, although some authors supported the effectiveness of antipsychotics in excoriation disorders, other authors, on the contrary, reported antipsychotic-induced skin picking. In particular, it has been recently described in the case of a young schizophrenic woman who developed self-induced ulcers on her lips and cheeks during clozapine titration.<sup>8</sup> It has been hypothesized that this phenomenon could be related to the strong anti-serotonergic activity of clozapine, responsible for the supersensitivity of 5-HT<sub>2A</sub> receptors and leading, in turn, to the repetitive behavior.<sup>8</sup> Although antipsychotics that exert a strong antidopaminergic effect on mesolimbic receptors (overstimulated in self-injurious behaviors)<sup>9</sup> could be useful in skin-picking treatment, those exerting an antiserotonergic activity could induce themselves skin-picking behavior.

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