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CASE REPORT

The Efficacy of Risperidone on the Treatment of Very-Early Onset Skin Picking Disorder

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Abstract

Skin picking disorder (SPD) has frequently been reported to start before the age of 10; but "very-early onset" type was not defined before in the literature. Also, research on the treatment of SPD in childhood is limited. We presented a "very-early onset" SPD case whose symptoms have started on the age of 4 and escalated with her comorbid oppositional defiant disorder diagnosis. Patient was successfully treated with low dose (0.25 mg/day) risperidone and proper psychoeducational interventions. Identifying SPD in very early childhood is hard cause; criterion of SPD might not capture all the specific features which very young children manifest and clinicians might overlook their complaints. Efficacy of risperidone might reflect a shared psychopathological etiology between impulse control and SPD, and lead future research on treatment of SPD with atypical anti-psychotics.

Keywords: Skin Picking Disorder, Very-Early Onset, Diagnosis, Treatment

INTRODUCTION

Skin picking disorder (SPD) is a new psychiatric disorder which is categorized under "Obsessive-Compulsive and Related Disorders (OCRD)" in DSM-5 and characterized by recurrent and persistent picking/scratching of skin and/or scar tissues. Any underlying dermatological causes should be ruled out beforehand in order to make the SPD diagnosis (1). SPD may start at any age but the age of onset is mostly during adolescence (2) we examined the psychometric properties of the Skin Picking Impact Scale (SPIS; Keuthen, Deckersbach, Wilhelm et al., 2001. Although onset before the age of 10 is frequently described; to our knowledge reports on "very-early onset" type of SPD are quite limited (3). Furthermore, evidence on the treatment modalities for SPD in pediatric cases is not fully explored (3). In this study we aimed to present a "very-early onset" SPD case with comorbid oppositional defiant disorder (ODD) who was successfully treated with low dose risperidone.

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CASE

Female patient aged 4 years 5 months, was brought to our child and adolescent psychiatry out-patient unit by her parents. She was living with her parents and recently had a newborn brother 8 months ago. She had been excoriating/picking her skin and making dermal scars for the last 4 months. In addition, she recently started exhibiting stubbornness, defiant behavior and became an over-orderly and over-meticulous child. She was over-involved in thoughts about getting dirty or sick and was refusing to let anyone sit next to her because they might be filthy. Her parents could somehow control her skin picking during day time; but she was excessively skin picking while trying to sleep at nights and waking up with her cloths covered in blood. She was not only picking her scars; but also trying to pick the veins under her tongue because she thought they were scars as well. She was an easygoing and compliant child before the mother's pregnancy; but towards the end of the pregnancy, she became more restless and troubled and even started

punching the belly of her mother. After her brother was born, she started having anger tantrums and physical hostility towards him. In time, her symptoms evolved into obsessive/compulsive features such as spending excessive time on cleanliness, not touching objects which other people have recently touched, constantly asking same questions to get the approval of others and picking her skin/scars.

Birth history revealed that she had a term birth; but C-section was needed because of breech presentation. She stayed in incubator for 2 weeks after her birth. Her developmental history revealed lagging in motor functions and language skills. She had no history of neurologic illnesses and her routine blood tests, cell-counts, neuro-physical examinations and magnetic resonance imaging results were normal. Her dermatological consultation ruled out any potential organic cause. During her psychiatric examination she was irritable, defiant, reluctant to cooperate and communicate. She was constantly pulling her father's clothes trying to persuade him to leave the room and over time she became more uneasy and started having an anger tantrum. Due to no available clinical severity scales for her age, Child's Global Assesment Scale (CGAS) was used to assess her functionality. Her initial psychiatric diagnosis was SPD with comorbid ODD and CGAS score was 45. Her parents were given basic psychoeducational information on handling anger tantrums, defiant behaviors, skin picking and compulsive questions. Because of her young age we aimed to avoid multi-drug use and target all of her obsessive/compulsive, irritable and impulsive symptoms; we administered a low-dose risperidone treatment (0.25 mg/day). On her follow-up examination after 1 month, her CGAS score was increased to 75 (66.7% improvement in functioning) and clinical symptoms (including obsessive/compulsive symptoms) were almost non-existent; so same medication was continued for 6 months. She was evaluated on monthly intervals and her follow-up showed further improvement in CGAS. After 6 months risperidone was discontinued and her next monthly follow-up showed no worsening of symptoms/CGAS. She is still stable on her psychiatric controls every 6-months.

This study has been performed in accordance with the ethical standards and the parents of the patient had given assent and written consent for the child to be presented in this case report.

DISCUSSION

OCRD and especially SPD is a fairly new and under-explored area of interests. Information on epidemiology, symptomatology and treatment of SPD is quite limited especially in the pediatric age group (4). SPD has a tri-modal peak of incidence; first peak before the age of 10, second peak during adolescence/young adulthood followed by a third peak between 30 and 45 years (3). Even though there is no criterion for "very-early onset" SPD; findings suggest that average onset during adolescence is the most commonly reported clinical presentation and numerous researchers have acknowledged onset during adolescence as "early onset" (4). Epidemiology of this new disorder is recently beginning to shape and evidence of SPD before the age of 6 is limited; thus we believe onset at age of 4 that we observed in our case might reflect a "very-early onset" identifier. Neurobiological underpinnings of body-focused repetitive behaviors are centered on thalamo-cortical circuits, loss of inhibition and impulsiveness; all of which are majorly controlled with dopaminergic neurons (5). According to the evidence, effective treatment of OCRD involves a combination of CBT, antidepressants and antipsychotics (6). Despite the limited research on the treatment of SPD; most studies show that cognitive behavioral psychotherapy (CBT) should be the first line treatment of SPD and selective serotonin re-uptake inhibitors (SSRIs) (such as fluoxetine, citalopram) or N-acetylcysteine can be used as pharmacological agents in patients who don't respond to CBT (4).

To our knowledge; this is one of the first reports on SPD diagnosis with "very-early onset" apart from another case report of a 2-year-old case with SPD which was also successfully treated with risperidone (5). Reasons for limited evidence on SPD in early childhood could be explained in two aspects: Firstly, epidemiological studies on defining criterion of SPD are fairly new and they might not capture all the specific features which very young children manifest. Secondly, complaints about SPD during early childhood might be attributed to developmental stages and could be overlooked by clinicians. Due to limited self-expression skills of this age, SPD might simply be under-recognized and hard to differentiate. In this case, some sort of functionality assessment might guide clinicians in both diagnosis and screening for treatment response. In addition, lack of cognitive skills and tolerability issues of SSRIs in her age group has pushed us to explore new treatment modalities and because of the major role of dopamine

in the pathophysiology of SPD (and other body-focused repetitive behaviors) we chose low dose risperidone medication. Effective treatment with risperidone might be a stepping stone for the research on treatment of SPD with atypical anti-psychotics in other age groups; as well as an indicator of a shared psychopathological etiology between impulse control and OCRD. In conclusion, things we know about SPD is still limited (even more so in younger age) and further studies are needed in order to fully understand and manage this disorder.

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