



Commentary

Solving the Puzzle- Finding the Piece to Provide Peace

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There are so many fields of medicine that cross over in dermatology. As dermatologists, it is easy to co-manage and identify the psoriasis patient with psoriatic arthritis, the patient with alopecia receiving chemotherapy for their breast cancer, and the patient on dialysis with uremic pruritus. Conversely, the patient with the bugs crawling under their skin, the itchy elderly widower and the depressed acne patient become more of a challenge. One-third of all patients in dermatology have emotional isolated skin disorders [1]. The understanding of the complex relationship between the psyche and the skin is complex, fascinating and one that puzzles many dermatologists.

Psychodermatological disorders can be classified into four different categories: Psychophysiological disorders, Primary psychiatric disorders, Secondary psychiatric disorders and Cutaneous sensory disorders. Psychodermatological disorders are true dermatologic diseases that are exacerbated by emotional stressors. Conditions like atopic dermatitis, acne, perioral dermatitis, psoriasis and hyperhidrosis are all conditions that patients often times report worsen when they are under stress. Primary psychiatric disorders, on the other hand, have no real skin disease, but instead have serious psychopathy. The classic examples of these conditions are delusions of parasitosis, dermatitis artefacta, and trichotillomania. Secondary psychiatric disorders describe psychologic disorders that patients develop in response to their dermatologic disease. Vitiligo, acne, alopecia areata, hidradenitis suppurativa and psoriasis are all dermatologic conditions that can have a significant impact on the emotional health and well-being of a patient. Cutaneous sensory disorders are akin to chronic pain syndrome. These disorders are the dysaesthesia and unpleasant sensations of biting, stinging, burning and itching without any clear etiology. Cutaneous sensory disorders oftentimes may present with or without psychiatric disturbances, but depression and anxiety are the most common co-morbid conditions [2].

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There is an enormous amount of pressure put on a dermatologist when a patient presents to your office, especially when they have been seen by six other physicians for their complaint. We are often a patient's last hope. If after multiple visits, an organic cause has not yet presented itself, it is important that we take the time to shake out the details as to what is the underlying cause of their complaint. It can be hard to use your "third eye" for these cases when you are 45 minutes behind and there are six drug reps in the hallway harassing you. Sometimes bluntly asking a patient about what is going on in their life or simply asking, "Are you depressed?" Is enough to gain insight? Other times, open ended questions can be equally telling such as:

- How many hours of sleep do you get a night?
- Do you find joy in your hobbies like you used to?
- What activities do you enjoy?
- Do you have a support system?

Patients just want to be heard and have their feelings validated. It can take an extra five minutes, but I have found acknowledging an acne patient's frustrations, asking a psoriasis patient how they are dealing with their disease emotionally, or simply pausing to acknowledge a patient's struggles, can help to foster a trusting, safe environment that will allow the physician to ultimately identify the issue and fix it. Another tactic I often like to employ is asking a patient what their goal of this visit is and what are their thoughts on solving it? I try to incorporate my patients into making decisions about their treatment plan (within reason), which not only empowers them, but also holds them accountable to it.

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