

Psychogenic pruritus: rapid response with a combination of selective serotonin reuptake inhibitors and benzodiazepine

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Abstract

A 45-year-old woman presented to us with generalized pruritus for the last 6 years. The itch was moderate in intensity causing interference with her daily activities and sleep. The pruritus was maximum in the evenings and there was no seasonal variation. It was not associated with any skin lesion. She did not have associated complaints of pain or altered sensation over the affected sites. She was a known case of diabetes mellitus and hypertension for the last 6- years which were moderately controlled with her medications. There was no history of atopy and any other systemic illnesses such as hypothyroidism or chronic liver and kidney diseases. There was a history of significant family stressors before the initiation of these episodes and aggravation of itch was noted with various stressors. The itch did not improve with her medications taken over the years such as antihistamines, antifungals, and antibiotics. Recently, she also started noticing palpitation and sweating associated with these episodes. The intensity of pruritus based on visual analogue scale was 7.

INTRODUCTION

A 45-year-old woman presented to us with generalized pruritus for the last 6 years. The itch was moderate in intensity causing interference with her daily activities and sleep. The pruritus was maximum in the evenings and there was no seasonal variation. It was not associated with any skin lesion. She did not have associated complaints of pain or altered sensation over the affected sites. She was a known case of diabetes mellitus and hypertension for the last 6- years which were moderately controlled with her medications. There was no history of atopy and any other systemic illnesses such as hypothyroidism or chronic liver and kidney diseases. There was a history of significant family stressors before the initiation of these episodes and aggravation of itch was noted with various stressors. The itch did not improve with her medications taken over the years such as antihistamines, antifungals, and antibiotics. Recently, she also started noticing palpitation and sweating associated with these episodes. The intensity of pruritus based on visual analogue scale was 7.

Her general physical examination was within normal limits. The cutaneous examination did not reveal any skin lesion, xerosis, or scaling. A mental state examination revealed a sad mood and anxious affect. Laboratory evaluation including hemogram, renal, and liver function tests was within normal limits. With a diagnosis of psychogenic pruritus, we treated her with escitalopram and etizolam, and a good improvement was noted within 2 weeks of initiation of treatment with a reduction in visual analogue score from 7 to 3.

DISCUSSION

Psychogenic itch is defined as “an itch disorder where itch is at the center of the symptomatology and where psychological factors play an evident role in the triggering, intensity, aggravation, or persistence of the pruritus.”¹ It is also termed psychogenic pruritus, somatoform pruritus, functional itch disorder, non-organic pruritus, psychosomatic pruritus, or functional pruritus.^{2,3} Psychogenic pruritus is usually a diagnosis of exclusion and its

prevalence in the general population is unknown. In a case series of 195 patients in the dermatology outpatient department, the cause of itching was classified as somatoform in 10.5% of patients.⁴ There is a female predominance with the most common age of presentation being between 30 and 45 years of age.⁵ Clinically, these patients present with long-standing resistant itch with skin changes like excoriations, erosions, and hypopigmented atrophic scars over the accessible body sites such as the face, abdomen, extensors of extremities, upper back, and shoulder.⁶ The disease is associated with significant impairment in the quality of life as well as other psychological disorders like anxiety and depression.^{2,6}

Diagnostic criteria proposed by the French psychodermatology group require the presence of three compulsory and three of seven optional criteria for the diagnosis of psychogenic pruritus.⁷ Our patient fulfilled the compulsory criteria in the form of generalized pruritus without primary skin lesions, presence of pruritus for more than 6 weeks, and with no somatic cause. Among the optional criteria, our patient showed a chronological relationship of her pruritus with life stressors, variation in intensity associated with stress, nycthemeral variation, and predominance of symptoms during rest. She had symptoms of anxiety associated with pruritus episodes and her pruritus improved with psychotropic drugs.

Apart from general management of pruritus, management of psychogenic pruritus includes psychotherapy and psychopharmacotherapy. The drugs used include first-generation antihistamines, tricyclic antidepressants, tetracyclic antidepressants, selective serotonin reuptake inhibitors, antipsychotic drugs, benzodiazepines, and anticonvulsants.^{8,9,10} Our patient responded well to a combination of selective serotonin reuptake inhibitors and benzodiazepine. The choice of the drug must be tailored according to the personality traits of the patient. Selective serotonin reuptake inhibitors have been proposed to target compulsive effect of psychogenic pruritus in addition to its anti-depressant effect.¹⁰ Benzodiazepines are known to have anxiolytic, sedative and hypnotic effects and are indicated in patients with psychogenic pruritus with a background of anxiety.⁸

Thus, though, psychogenic pruritus is a diagnosis of exclusion and is a rare occurrence but knowledge of this entity is essential for early diagnosis and proper management of these patients. A combination of drugs may be used based on the patient's personality trait for effective management.

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