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When the Pain is Real but the Cause is Not: A Case of Leg Ulcer Pathomimia: Case Report

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Abstract | **Case Report**

This case highlights a rare and under-recognized cause of chronic leg ulcers: pathomimia, a factitious disorder in which patients deliberately produce or simulate symptoms without external incentives. We report the case of a 33-year-old Moroccan woman presenting with a painless ulcer on the lower third of her left leg, alongside severe depression, insomnia, and persecutory delusions. Despite extensive investigations including MRI, skin biopsy, and microbiological tests, no organic etiology was identified. The diagnosis of pathomimia was supported by the patient's indifference to her lesion and the psychiatric context. Treatment included sertraline, alprazolam, chlorpromazine, and daily dermatological care, resulting in significant clinical improvement. This case emphasizes the importance of considering psychiatric causes in atypical or non-healing dermatological presentations. Early multidisciplinary intervention is crucial to ensure accurate diagnosis and effective management, avoiding unnecessary investigations and prolonged morbidity.

Keywords: ulcer; leg; pathomimia; psychotherapy; depression.

INTRODUCTION

Leg ulcer is a chronic and painful skin lesion that can significantly impair patients' quality of life [1]. While most cases are attributed to vascular, infectious, or metabolic etiologies, factitious disorder remains a rare and often overlooked cause. This psychiatric condition, also known as Munchausen syndrome, involves the intentional production or feigning of symptoms without external incentives (DSM-5).

We present a unique and instructive case of a leg ulcer induced by factitious disorder. The diagnostic challenge it posed, combined with the risk of unnecessary medical interventions, underscores the importance of considering psychiatric etiologies in chronic non-healing wounds. This case highlights the need for multidisciplinary collaboration to ensure accurate diagnosis and appropriate management.

PATIENT AND OBSERVATION

Patient Information

We report the case of a 33-year-old Moroccan woman, single and illiterate, living with her family. She had no notable medical, surgical, or psychiatric history. The patient was admitted to the psychiatry department for depressive symptoms and insomnia evolving for two months. Her psychosocial background revealed a context of social isolation and emotional neglect. There was no known family history of psychiatric or dermatological disorders.

Clinical Findings

On psychiatric examination, the patient appeared tearful and reported persistent sadness, loss of interest and pleasure (anhedonia), fatigue despite adequate sleep, difficulty concentrating, feelings of worthlessness and guilt, as well as suicidal ideation. Additionally, she exhibited persecutory delusions with interpretative mechanisms involving family members. Her affect was congruent with her mood. The physical examination revealed a painless ulcer located on the lower third of the left leg. Interestingly, the patient showed marked indifference toward the lesion, perceiving it as foreign to her body.

Timeline of Current Episode

- 2 months before admission : Onset of depressive symptoms and insomnia ;

- At admission: Psychiatric and dermatological evaluations performed; discovery of leg ulcer;
- During hospitalization: Multidisciplinary investigations conducted; no organic etiology found;
- After initiation of treatment: Gradual improvement in both psychiatric state and skin lesion.

Diagnostic Assessment

Extensive investigations were carried out to identify the etiology of the leg ulcer. Infectious causes (cutaneous tuberculosis, leishmaniasis, deep mycoses), autoimmune diseases (rheumatoid arthritis, sarcoidosis, lupus), and neoplastic etiologies (squamous cell carcinoma, lymphoma, Kaposi's sarcoma) were considered.

The patient underwent:

- MRI of the leg;
- Two skin biopsies (one for histology, one for BAAR culture);
- Bacteriological and mycological swabs;
- Quantiferon test and BK search in sputum;
- Full blood count, viral serologies, immunoglobulin levels, tumor markers;
- CT thoraco-abdominopelvic (CTAP);
- Colonoscopy.

All test results were negative or inconclusive. The absence of a consistent organic explanation, the nature of the psychiatric symptoms, and the spontaneous healing of the lesion under supportive care led to the diagnosis of factitious disorder.

DIAGNOSIS

Final diagnosis: Factitious disorder (DSM-5 criteria met). Other diagnoses considered: infectious dermatoses, autoimmune diseases, neoplastic causes. Prognosis: Favorable with psychiatric care and therapeutic adherence.

Therapeutic Interventions

Pharmacologic treatment included:

- Sertraline 50 mg/day (antidepressant);
- Alprazolam 1 mg/day (anxiolytic);
- Chlorpromazine 25 mg/day (sedative, due to suicide risk).

Dermatological care consisted of daily wound cleansing and dressing with Vaseline, without specific pharmacological or surgical intervention. Behavioral psychotherapy was recommended following the diagnosis.

Follow-Up and Outcome of Interventions

During hospitalization, the patient showed marked clinical improvement: mood symptoms regressed, and the ulcer began to heal progressively. No adverse effects were observed. The patient was adherent to both psychiatric and dermatological management.

Patient Perspective

The patient reported feeling emotionally numb and abandoned prior to care. She perceived the ulcer as something "external" to her body and had lost hope in recovery. As her mental state improved, she began to accept help and expressed surprise and relief at the healing of her wound. She acknowledged the benefit of psychiatric support but remained emotionally guarded.

Informed Consent

Written informed consent was obtained from the patient for the publication of this case report and accompanying images.

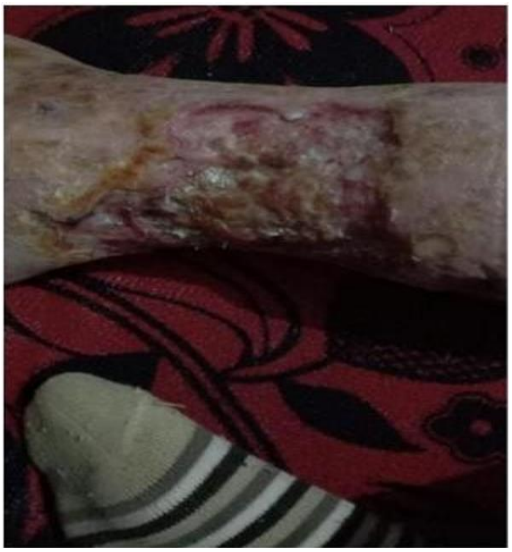


Image A

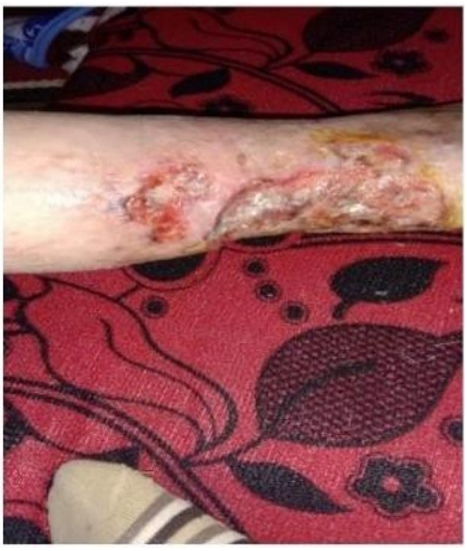
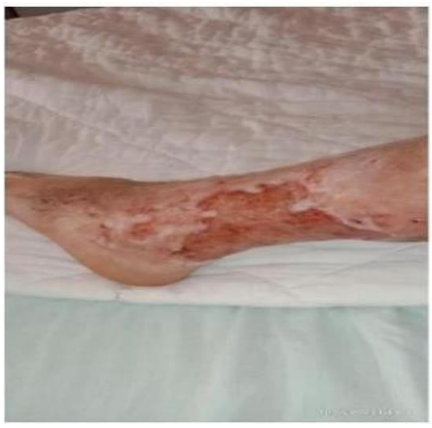


Image B



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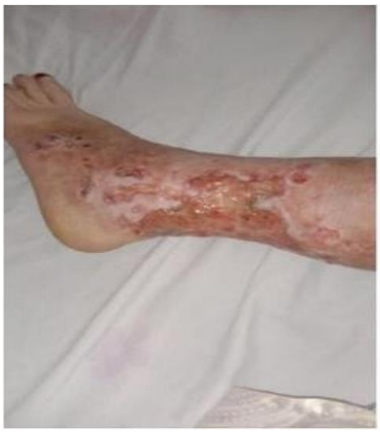

Image D

Sponaneous evolution, without specific dermatological treatment, During her hospitalizatio

DISCUSSION

This case of pathomimia illustrates a complex clinical picture, at the intersection of dermatology and psychiatry. Its main strength lies in the detailed description of an atypical chronic ulcerative lesion, allowing for a diagnosis that is often overlooked or delayed. The case also highlights the importance of a multidisciplinary approach for comprehensive care, both physical and psychological.

However, certain limitations must be noted. The diagnosis of pathomimia remains essentially clinical and relies on observation, history, and monitoring progress. The lack of objective diagnostic criteria or biological markers complicates diagnosis confirmation, and the use of prolonged hospitalization for observation can raise ethical and practical considerations. Furthermore, the patient's progress after the therapeutic intervention, particularly in terms of relapses or adherence to psychiatric follow-up, could not be documented over the long term.

Scientifically, the literature describes pathomimia as a rare entity, representing approximately 0.2% of dermatology consultations, primarily affecting young adults between 15 and 35 years of age, with a clear predominance in women [2]. The lesions are most often ulcers with sharp edges, appearing suddenly on initially healthy skin, and healing slowly, frequently complicated by secondary infections [3].

Delayed healing in the absence of an identifiable organic cause (anemia, malnutrition, vascular disorders) should raise this diagnosis [4,5]. In some cases, the lesions can be more extensive, associated with worrying scar retractions. A study conducted by [6] shows that patients with pathomimia frequently present with non-healing leg ulcers, with a tendency to interrupt treatment, change dressings, and neglect care, thus contributing to chronicity and scarring sequelae. Other studies corroborate these data, highlighting that pathomimy worsens the prognosis of ulcers by prolonging healing times and promoting recurrence [7,8].

The literature also highlights the frequency of self-mutilation behaviors in these patients, which increases the risk of infection and poor healing [1][4]. Psychopathologically, these patients often present a complex profile, marked by high levels of stress, anxiety, and depression [7]. This psychological morbidity, coupled with the duration of treatment and physical limitations, can lead to feelings of helplessness and discouragement. Family and caregivers are also subjected to a significant emotional burden, linked to the fear of relapse and the need for constant vigilance.

In this context, it is essential to take these psychological elements into account when developing holistic treatment strategies, combining dermatological care, psychological support, and psychiatric follow-up [9]. The management of a leg ulcer secondary to pathomimia almost always requires hospitalization, allowing for rigorous supervision, strengthening of the therapeutic alliance, assessment of compliance, and preparation for possible surgical intervention.

The use of occlusive dressings is a practical solution to prevent repeated manipulation of lesions by the patient and limit self-inflicted trauma [10]. Psychiatric care is essential, as pathomimia involves the unconscious or deliberate simulation of medical symptoms. It requires close collaboration between psychiatrists, dermatologists, and somatic care teams [11]. Emotional support, cognitive-behavioral therapies, and exploration of possible underlying traumas allow for synergy with medical treatments. Integrated care, taking into account both physical and psychological dimensions, is therefore essential to improve patients' quality of life [12].

CONCLUSION

This case underlines the importance of recognizing pathomimesis as a potential cause of chronic and atypical skin lesions such as leg ulcers.

Misinterpreting these symptoms as purely organic can lead to delayed diagnosis, unnecessary medical procedures, and prolonged patient suffering. Early identification relies on careful clinical evaluation and a high index of suspicion, especially when lesions are inconsistent with known medical conditions or fail to respond to standard treatments. A multidisciplinary approach, integrating dermatological assessment, psychiatric evaluation, and psychological support, is essential for effective care. Ultimately, understanding the psychological dimensions of pathomimesis allows for more compassionate, individualized treatment, and contributes to improved quality of life for affected patients.

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