A Case Series of Underreported Dermatologic Conditions in Psychiatric Inpatients: Challenges, Preventable Morbidity, and Practical Management

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Introduction

Dermatologic conditions related to impaired self-care are common yet frequently overlooked sources of morbidity in patients with severe mental illness. Psychiatric inpatients often develop skin disorders associated with poor hygiene, including fungal infections, dermatitis, xerosis, hyperkeratosis, bacterial infections, and hair disorders. These conditions are often underreported and may go unrecognized until patients raise concerns or findings are discovered incidentally.[1-3]

Recognition and management are further complicated in psychiatric inpatient units by structural and safety-related limitations. Restrictions on grooming tools (e.g., nail clippers, razors, brushes), limited dermatology consultation, and the absence of standardized care protocols may delay diagnosis and treatment.[4-5]

We present a case series describing onychocryptosis, dermatitis neglecta with plica neuropathica, and stasis dermatitis with ulceration. These cases highlight diagnostic challenges and practical bedside management strategies that can be implemented in psychiatric inpatient units with limited dermatology consultations.

Case Presentations

Case 1: Onychocryptosis

A 23-year-old woman with schizoaffective disorder was admitted under a Temporary Detention Order for severe psychosis with hallucinations, paranoid delusions, and suicidal/homicidal ideation. Her hospitalization was prolonged due to medication stabilization. On hospital day 16, she reported pain along the medial aspect of the left great toe. Examination revealed erythema, edema, and partial embedding of the nail plate into the medial nail fold without drainage or cellulitis, consistent with Stage I onychocryptosis (Mozena classification). The patient had been unable to maintain routine nail care due to safety restrictions on grooming tools. Treatment with topical bacitracin/neomycin/polymyxin B twice daily resulted in resolution of inflammation and improvement of symptoms.

Case 2: Dermatitis Neglecta and Plica Neuropathica

A 41-year-old woman with schizoaffective disorder and severe self-neglect was admitted involuntarily after medication nonadherence and poor hygiene. She reported bathing approximately once per month. Examination revealed yellow-brown hyperkeratotic plaques with laminated crust on the face and severely matted scalp hair. She was initially treated with cephalexin for presumed impetigo. However, assisted showering removed large sheets of keratinous debris, revealing normal underlying skin and confirming the diagnosis of dermatitis neglecta. Persistent scalp matting was consistent with plica neuropathica. With repeated assisted hygiene, heated shampoo caps, and partial trimming of matted hair, skin findings resolved, and hair became manageable during hospitalization.

Case 3: Stasis Dermatitis with Ulceration

During a subsequent psychiatric admission, the same patient again demonstrated profound self-neglect and hygiene refusal. She presented with persistent leukocytosis, hypertension, fatigue, and diffusely xerotic skin. On hospital day 7, examination revealed bilateral lower-extremity edema and necrotic eschar-covered plaques on the anterior right lower leg, with smaller eschars on the left leg. Imaging ruled out deep vein thrombosis. Findings were consistent with stasis dermatitis with secondary cellulitis in the setting of obesity, immobility, edema, and impaired hygiene. Empiric cephalexin was initiated. Wound cultures later grew Acinetobacter baumannii, prompting transition to minocycline. With wound care, hygiene support, and improved mobility, symptoms improved, though edema persisted.

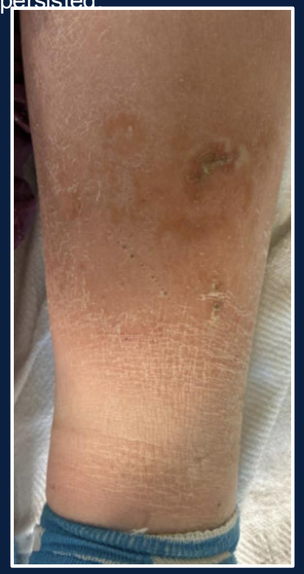

Fig 1. Stasis Dermatitis on the anterior lower legs

Fig 2. Stasis Dermatitis with Ulceration of **the a**nterior right lower leg

Fig 3. Onychocryptosis of the left hallux

Discussion

- Dermatologic conditions are common but underreported in psychiatric inpatients, often resulting from impaired self-care, cognitive disorganization, immobility, and limited hygiene support.[3]
- Diagnostic overshadowing and patient unawareness frequently delay recognition and treatment and often lead to misdiagnosis, resulting in unnecessary interventions, prolonged morbidity, and preventable complications. [6]
- Institutional safety restrictions (e.g., limited access to nail clippers, razors, or grooming tools) can unintentionally increase the risk of dermatologic morbidity.
- Basic bedside evaluation and hygiene interventions can be highly diagnostic and therapeutic, particularly for neglect-related conditions such as dermatitis neglecta.[7]
- Misdiagnosis may lead to unnecessary antimicrobial therapy, emphasizing the importance of conservative evaluation and antibiotic stewardship when systemic infection is not suspected.
- Structured hygiene support and routine skin, scalp, and nail assessments can facilitate early detection and prevent progression of conditions such as onychocryptosis, plica neuropathica, and stasis dermatitis.
- Adapted management strategies are often required in psychiatric units, including supervised grooming, alternative compression methods, mobility support, and simplified self-care interventions.
- Interdisciplinary collaboration among psychiatry, nursing, dermatology, podiatry, wound care, and rehabilitation services is essential to reduce preventable dermatologic morbidity.

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Disclosure

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