Why Does My Skin "Feel" So Funny? Dysesthesias

Richard Fried, MD, Ph.D., interviewed by Steven Shama, MD

STEVEN SHAMA, MD: This is Dr. Steve Shama. It's my pleasure to interview Richard Fried. He has an M.D. and a Ph.D. He a dermatologist. He's also a clinical psychologist. He's the Clinical Director of the Yardley Dermatology Associates and also the Yardley Clinical Research Associates. Rick, thank you very much for talking to me on *Dialogues*.

RICHARD FRIED, MD, PhD: Steve, pleasure to be here.

STEVEN SHAMA, MD: Can we begin with just the definition of dysesthesias and then separate it out from the other esthesias that we know about, like paresthesias?

RICHARD FRIED, MD, PhD: Absolutely. I think for so many of us, when we think about alteration in skin sensation, we tend to think of pain or itch. But there's really a much broader spectrum than that. And dysesthesia, by definition, is any uncomfortable sensation in the skin. What differentiates dysesthesia from so many of the other entities, like hyperesthesia or hypoesthesia, is that the dysesthesia can be absolutely spontaneous in nature. It's not necessarily elicited by outside forces. It's just this miserable sensation that can include itch, tingle, burning, pain, crawling, biting, any sensation you can imagine. Whereas the hypoesthesia, yes, when we touch them they feel the sensation less. The hyperesthesia, when we touch them, they feel it more. But the dysesthesia just seems to have a mind of its own.

STEVEN SHAMA, MD: So it's spontaneous and it can be elicited, too. In other words, if I touch someone with a dysesthesia, they might say, "I feel it and it's painful." And I say, "I just touched

you very lightly," so it's out of proportion and different than I would have expected, is that part of it, too?

RICHARD FRIED, MD, PhD: Absolutely, absolutely. They can coexist and it can be an exaggerated reaction to normal touch. Or the sensory exam, the typical sensory exam, could be totally normal. But they are just absolutely devastated by the chronicity of the dysesthesias.

STEVEN SHAMA, MD: Okay. I want to ask you a question. Because everyone knows you have a Ph.D. in psychology and you're a clinical psychologist. So immediately, most of us, and myself included, are saying, "This is all in someone's mind." But that's not necessarily the case, is it?

RICHARD FRIED, MD, PhD: I honestly believe that the majority of dysesthesias are organic in nature. Whether we can actually document them by skin biopsy, by functional MRI, sometimes we can, sometimes we can't. The other issue is, with chronicity, whether the dysesthesia began as an allergic contact dermatitis, an infestation, or it began as a fear of infection, with chronicity, I think there's an overlap where they become both organic and psychogenic in nature. You know, when someone says, "My skin feels funny," it's really not terribly funny. Because when there's an alteration in sensation with no good reason for it, people begin to become exceedingly anxious about why. And do I have an infection? Do I have cancer? Do I have AIDS? And the more terrified they become, the more focused they become on the negative sensation. That intensifies the sensation. The anxiety leads to more and more intensification and it becomes a vicious cycle that honestly can begin to own the person or, in the extreme, actually lead them to total dysfunction and suicidal ideation or frank suicide.

STEVEN SHAMA, MD: Where is the pathology? Show me where it is or I have to find it. If I can't find it, then I have to look, is it perceived? But these people are in pain. Something is going on with them. And our job is to find out if there's something organically going on. Now, let's take

the organic and then we'll deal with the psychology after that. What could have set something off? Let's do someone who comes in perhaps with a groin itch, would that be fair to say?

RICHARD FRIED, MD, PhD: Absolutely.

STEVEN SHAMA, MD: Alright. And there's no pathology but there's a history of perhaps some pathology.

RICHARD FRIED, MD, PhD: If you use the analogy there of a postherpetic neuralgia. After there's been a groin inflammation, be it a frank tinea pedis, chronic intertrigo, the threshold of firing for the C fibers and other cutaneous elements lowers. So they may inappropriately fire at the neuronal level. They may inappropriately release neuropeptide substance P, calcitonin gene-reacted peptide. So their threshold may be just so much lower that they're experiencing these chronic sensations, if you will, the "as-if" sensations, as if something is still going on.

STEVEN SHAMA, MD: Alright, so let me go over this again. I'm seeing a guy who has a groin itch. And he tells me that he's been seeing a lot of other people, some of them may have a contact dermatitis kind of thing. He modified his underwear, his detergent, and whatnot. Some people said he had tinea cruris and they gave him some antifungals and things got better. But he said, "They're not better and I've been recommended to see you, because I know you're a contact person like myself." And I'm saying, "I don't see anything over here." So I put him through a patch test and I find nothing. And then I'm saying, "Am I dealing with a dysesthesia?" Is that a – is that what may be happening over here?

RICHARD FRIED, MD, PhD: Absolutely. And perhaps the autosensitization reaction or the id, post allergic contact dermatitis, is analogous again, where you have activated T cells that continue to behave as-if.

STEVEN SHAMA, MD: So, you know, let's assume you've cleared things up and someone is still complaining of symptoms. How long can they complain about it until you say, "You know what? I'm dealing with a dysesthesia here." It's not real pathology in the organic way, but there's a psychological mechanism over here. Can it go on for three weeks, six months? And at six months you just say, "Aha, now I don't have to work up this person anymore. I can just switch him to someone like Rick here and let him take over"?

RICHARD FRIED, MD, PhD: Right. Dysesthesias can last three months, three years. When it becomes meaningful is when it's a symptom that just will not abate, does not respond to traditional therapy, and is causing them a degree of psychological distress. One of the important questions with a dysesthesia is, is the symptom existing in isolation or is this symptom accompanied by behaviors on the part of the owner? Often because of fears and beliefs about what's causing it, we find people are overmedicating, people are sometimes scratching, people are sometimes digging, people are sometimes using all kinds of herbals. So there's sometimes secondary exacerbation from anything from friction, to allergic contact dermatitis, to just frank skin excoriation. So how they feel about how they feel is a big deal. And by the time we see them, often we have to go through that differential diagnosis. And frankly, from my point of view, any chronic dysesthesia is a paraneoplastic presentation until proven otherwise. Any chronic dysesthesia is a metabolic, infectious, or autoimmune until proven otherwise. And it's not good enough to prove it once. One's have a way of piling by, as we all know. If they at six months are still with the same symptoms if they've had serologic studies, imaging studies, they need to be repeated.

STEVEN SHAMA, MD: You have to revisit these people and maybe even re-biopsy things that you've biopsied before?

RICHARD FRIED, MD, PhD: Absolutely. I had a gentleman sent to me several years ago who was sent by his primary care doctor as being, in quotes, “a total nut,” unquote. In fact, he was a nervous wreck, rambling speech, pressured speech, really a mess to try to get him focused. He said he had intractable, intractable itch, burning, and biting. Had a kind of colored and storied past, in terms of some of his extramarital behaviors. And when I examined him, I didn’t see much, except for excoriations. Did a skin biopsy. Basically, a GS showed nonspecific excoriations, a couple lymphocytes. Six months later, biopsied him again. A couple of atypical lymphocytes. Six months later, frank CTCL. So the question is, was this a “crazy guy,” in quotes, who developed CTCL? Or was his itch from day one a presentation of his underlying malignancy? So our obligation is to remain vigilant. And I think perhaps the most important thing, when these patients come in, again they’re terrified. They’ve had complete control ripped away from them. They cannot control, predict, or understand their symptoms. So the approach I think that is very helpful with every patient with dysesthesias is a promise. And the promise is, I promise you we will remain incredibly vigilant in a search for anything underlying that’s causing this, whether it’s an infection. Whether it’s an infestation. Frankly, whether it’s some kind of cancer. We will never stop watching. The second part of it is to help them understand that something has become different about their nerve endings. Their nerve endings are inappropriately firing and giving these awful sensations. And nerve endings have a limited repertoire when they fire. It can be itch, tingle, burn, pain crawl. So our job is to normalize the responsivity of their nerve endings. And we’re going to do that using sometimes creams, sometimes lotions, sometimes pills. Crucial is that we tell them we’re not going to suppress or shut off those nerve endings. Because deep in their heart, they’re terrified if you shut those nerve endings off, they’re not going to tell me, they’re not going to signal me when that big, bad bear may come out. So I tell them, “We’re going to normalize the nerve endings, so they respond appropriately when they need to and they should, but not inappropriately, making you

miserable. We can give you your life back. We can give you your normal routine back." And again, stay absolutely on guard.

STEVEN SHAMA, MD: Here's a story. I'm someone who comes in. I have localized itching versus generalized itching. A different kind of concern. Let's assume groin. Where are the areas that you most likely will find someone with dysesthesias presenting?

RICHARD FRIED, MD, PhD: Great question. I think groin is probably perhaps number one. Face, very common. Hands and feet, very common. And I'm – and in the scalp, as well. And I'm glad you brought that up because certain areas have terrifically symbolic significance to people. There's an article I wrote last year called "Vegas Dysesthesia: What Happens There Stays Where?" And many of us have had the occasion of having a male patient come in with chronic groin itch or tingle or burn, convinced they've contracted something. And at some later date confess, you know, "I was in Vegas and I had a contact that I was terrified about. And scrubbed and rubbed and out, damn spot. And these symptoms continued." So for that individual, they're terrified that they've caught something perhaps because of chance, perhaps because of some attribution from a power above. But nonetheless, they need A) a workup, to make sure they did not, in fact, contract an STD. B) They need to stop over-washing, over-cleansing, over-scrubbing. And then C) they need appropriate medicaments. On the face, people are terrified on the face that it's going to change their appearance, perhaps become destructive and disfiguring. So the locations have a lot of emotional significance for many, many people. Destroy the emotional reaction, the more intensified the dysesthesia often becomes. So frankly, we've got to treat three things. We've got to treat the sensation. Ideally, if we can find the cause, treat the cause of the sensation. Then we have to treat the emotional concomitant or response. Which in some people is depression. In some people, it's anxiety. In some people, it's OCD. Alcoholics Anonymous has a wonderful expression, "Any thought nurtured long enough becomes an

obsession." And unquestionably, dysesthesias lead to obsessive, obsessive perseveration. And that's when we've got to take a multifaceted approach.

STEVEN SHAMA, MD: You know, you've made me feel like I'm not crazy. If I were the patient, that this is something that happens to people and I'm not just imagining it, it is real in some way, shape, or form. I think that's very, very important.

RICHARD FRIED, MD, PhD: I think you hit the nail just precisely on the head. And these are people who are dismissed as being nuts. They can't sleep. They can't function. They're becoming convinced they're nuts.

STEVEN SHAMA, MD: Now, are there drugs or things like that that can set this off? To make it easy for me, like if I'm an alcoholic and stopping drinking, or if I'm stopping taking medications, or taking medications, can some of these things in your review of history say, "You know what? Let's see if this is going to get by with this and this"?

RICHARD FRIED, MD, PhD: Absolutely. Drugs, bugs, food. And maybe prescription drugs, with the amount of opiates that people are on these days, it might be recreational drug use. As all of us know, many, many common street drugs, be they marijuana or others, are laced with things which can be enormously iatrogenic, withdrawal from alcohol, herbals. Some of the herbals we see certainly drug reactions and chronic itching. Anything that crosses our lips, there's no question.

STEVEN SHAMA, MD: Yeah, I'm sensing, Rick, that this is an end of the day patient for you. In other words, you don't want to get behind. You want to really take your time with them, the first time you see them. And, in fact, the second and third times.

RICHARD FRIED, MD, PhD: Ideally, they are end of the day patients. Do they end up being so? No. One can argue the dysesthetic patient, whether they're the patient with delusions of

parasitosis or they're a patient with chronic burning, may perhaps be easier than the cosmetic patient with 8-1/2 x 11 list of complaints and concerns. But I think once we get the message across to these patients is, as you articulated so well, that there is a biological basis. And we have treated hundreds of people. And we have the tools. And the tools can be in the form of topicals, anything from topical corticosteroids, topical calcineurin inhibitors, topical amitriptyline cream or lotion, topical doxepin, many of these symptom, sensation-altering things, whether it's Sarna, whether it's any of the other menthol-based products, sometimes cold applications. So we have a wonderful collection of topicals. If that doesn't do it certainly, many people by the time they see us have tried antihistamines, both sedating and nonsedating. Sometimes adding an H2 blocker on board, if there's a histamine component to the itch, can be very, very beneficial. Cyproheptadine can be very beneficial if there's itch and histamine at work. Moving into some of the, in quotes, psychiatric medicines, the tricyclic antidepressants. Classically, doxepin we've all used. And, you know, we kid ourselves as dermatologists when we say, "You know, we don't like to prescribe psychotropic medicines." Frankly, if you look at the pharmacologic structure of Benadryl, it's not far from Thorazine. Doxepin clearly, we say we only use it in lower dose, it's a tricyclic antidepressant and TCAs are beautiful at inhibiting histamine release. And in modulating some of the emotional response. Amitriptyline particularly for scalp dysesthesias remains one of the drugs of choice. Dosages, we tend to use lower dosages than we do for psychological conditions. For doxepin, 10 to 25 to 50 to 100. For amitriptyline, we're talking about again starting it low, dosing it 10 mg, titrating up to the 100 to 150 mg, as needed. The newer generations, the SSRIs, be they fluoxetine, paroxetine, sertraline. I honestly don't believe there's a SSRI of choice, that you can look at a given individual and say, "Jim Jones is going to do well with sertraline versus Sandy, who's going to do well with paroxetine." I think it's a matter of starting low, going slow, much as many of us do with isotretinoin. But nonetheless, the SSRI can be exceedingly helpful for obsessive ideation for the anxiety and for the depressive symptoms. For the tougher players, the SNRIs, medicines

like venlafaxine 50 to 300 mg. The SNRIs, as you know, cover both serotonin and norepinephrine.

STEVEN SHAMA, MD: Okay. I was going to ask you what the SSNRs were.

RICHARD FRIED, MD, PhD: And norepinephrine for some people play a larger role or at least an equal role. We know that the inflammation that is in the skin from chronically excoriated skin, from primary inflammatory skin disease, we learned in 2010 that those inflammatory mediators don't just stay in the skin, they cross the blood-brain barrier. When they enter the brain, what they do is they enhance reuptake of neuropeptides. So they actually lower neurotransmitter levels at the synapse. So the secondary diminution of neurotransmitters again makes people more anxious, more depressed, more distressed, and intensity the symptom. So normalizing some of those levels at the level of the synapse, important.

STEVEN SHAMA, MD: I think one of the biggest things you were talking about, Rick, in the *Dialogue* today, is that they're not necessarily crazy, although you can label them as that easily and dismiss them and you have to have a heart and you have to have plenty of time. Let me ask you a couple of closing responses over here. Number one, one of the biggest things I suppose is to tell someone, "I don't believe you're crazy, and there is a place for you, in the way I think, and that this will get better. I can't guarantee it but it will get better."

RICHARD FRIED, MD, PhD: Absolutely, absolutely.

STEVEN SHAMA, MD: Right? Those are the two things that I think. When reading your very good article that you made reference to, is that correct, that was the vagal--?

RICHARD FRIED, MD, PhD: Yes. Yes. And letting them know that you strongly do not feel they're crazy, even though, my God, if I were living with these symptoms I would begin to wonder, am I crazy? So I'm sure at times, you feel that way. But you have a right to. And we

have the tools to fix this. As a psychologist, I am a control freak. I don't want to control anyone. I want to give it to people. And I think if we look across the spectrum of what we do on a daily basis as dermatologists, whether it's psoriasis, eczema, rosacea, whether it's skin cancer, whether it's dysesthesia, we're in the business of giving people an enhanced sense of control over their skin, over their body, and ultimately over their emotional reaction.

STEVEN SHAMA, MD: Yeah, I'm reading something that you said. Maybe you can continue this. "Never assume that they're crazy but also never assume that the crazy person can't be sick. And be ever-vigilant in terms of your evaluation of these people."

RICHARD FRIED, MD, PhD: Absolutely, that's--.

STEVEN SHAMA, MD: And these are your words, I want to give everyone--.

RICHARD FRIED, MD, PhD: Yeah. There's an old joke about the hypochondriac. On his tombstone it says, "I told you I was sick." So yes, even crazy people do get sick. And delusions of parasitosis, very quickly. This is the patient that nobody wants to take care of, let's just ship them off. There are two groups of delusions of parasitosis. There are the delusional patients who truly believe that they are infested with bugs. They'll tell you about them. They see them. They'll tell you about their mating habits. Then there are the delusions of parasitosis, in quotes, patient, who have horrible biting sensations. God forbid anyone listening to this wakes up tomorrow morning with biting, crawling sensations on their skin. Their attribution is going to be "I've got bugs." So sometimes, it's pure neuropathic. Sometimes, it's pure psychogenic. But it always becomes both. With pickers, do people pick because their skin itches, tingles, hurts, or burns? Or do they pick it because they're what to do? There's an article written recently that I wrote on skin pickers, could skin picking, neurotic excoriations, be a forme fruste of Tourette's disorder? One milligram of pimozide often shuts these people down. Quantify the sensation. Tell them to please let you know exactly what they feel and then what do they do in response to it. If

they rub it, pick it, ask them, “Are you always picking or rubbing in response to the sensation? Or is kind of just what you do?” And for a lot of people, they’ll say, “You know what? It’s kind of what I do.” For those people with functionally autonomous scratch and pick, sometimes pimozide at ridiculously low dose, SSRIs can literally just melt it away. And they’ll come back in and say, “You know, it’s a funny thing. I’m just not feeling it and I’m just not there as much anymore.”

STEVEN SHAMA, MD: Yeah, okay. And never give up on them. And always be vigilant, if something isn’t getting better, we’ll rebiopsy, reevaluate, and spend enough time with them.

RICHARD FRIED, MD, PhD: Absolutely. Absolutely.

STEVEN SHAMA, MD: Yeah, this has been very, very wonderful, Rick. I thank you very much. I hope people have gotten – listeners, as much as I’ve gotten out of this. I know you care very much and I think many of the messages that we, as physicians, have to give, especially as dermatologists, when someone comes in being labeled by other people as kind of weird and crazy, is to say, “I don’t believe that’s what’s happening and I’ll do the best I can to make you better.”

RICHARD FRIED, MD, PhD: And Steve, you and I passionately believe we can heal. We do. We, meaning you and I, we meaning every clinician out there. And it’s a grateful privilege, because these are the kind of patients that, my God, when you improve their symptoms, it’s literally giving them their life back.

STEVEN SHAMA, MD: Yeah. Rick, thanks very much for the time. It was a pleasure.

RICHARD FRIED, MD, PhD: Thank you, the same here.