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Factitious disorder: a case report with clinical guidance for management

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Abstract

Although the hospitalization of a patient with factitious disorder (FD) can incur healthcare costs that exceed \$200,000, it also incurs a tremendous psychological impact on healthcare staff. We present the case of Ms. L, a 38 year old Caucasian female with severe FD. We examine psychosocial factors associated with FD and offer strategies for inpatient physicians to collaboratively manage this condition.

Ms. L presented to the ED after ingesting multiple batteries. Although this acute medical issue resolved within 1 week, Ms. L was hospitalized for months. Her symptomatology was encapsulated by two themes: suicidal ideation by starvation, and ‘seizures’. Shortly after Ms. L was cleared medically, she began to be interviewed for placement. During this period, Ms. L declared that she would attempt to kill herself by starvation and developed a curious ‘seizure’ disorder. The escalation of Ms. L’s medical acuity led to a preponderance of rejections for placement. When Ms. L understood this, she happily resumed eating and drinking. Furthermore, her ‘seizures’ were initially treated with standard anti-epileptic drug regimens, which paradoxically exacerbated her symptoms. It became clear that Ms. L feigned symptoms because it provided attention through positive and/or negative reinforcement. Eventually the primary team only began to monitor Ms. L from afar without alerting her to the team’s presence, and the lack of any reinforcement terminated all ‘seizure’ symptoms.

Background

- Symptomatology of patients with FD can manifest as ‘pathologies’ in a broad array of disciplines: dermatology, ENT, and even decompression sickness¹⁻⁷
- Dermatitis artefacta, otolaryngology fantastica
- Previous literature demonstrates trends in this patient population⁸
- Occupation: healthcare industry
- Gender: f>m
- Age: mid-30’s
- Co-morbid psychiatric conditions in 37% of cases
- Medical teams are faced with medical and ethical dilemmas

Case introduction

Ms. L is a middle aged Caucasian female who presented to Henry Ford Hospital (HFH) in Detroit, Michigan from her AFC home after swallowing multiple batteries. At the ED, emergent EGD was successful in retrieving only 1 battery. She was admitted to the general medicine unit for further management. The batteries were followed with repeat serial abdominal imaging and after several days the remaining batteries were removed by the gastroenterology team by scope through Ms. L’s ostomy bag without surgical or post-surgical complications.

Although this acute medical issue had resolved within 1 week, when we assumed care of Ms. L, she had spent 1 month on the general medicine floor.

Suicide by refusal to eat

- Protest began after Ms. L was medically cleared and awaiting placement
- Primary team concerns vs psychiatry team concerns
- Development of metabolic derangements necessitated dohoff placement
- Negatively impacted interviews for a new AFC homes
- Preponderance of rejections
- As the number of prospects decreased we continued to update Ms. L
- Simultaneous mood improvements
- Eating and drinking with dohoff still in place
- All AFC group homes refused
- All psychiatric inpatient facilities refused
- Agreed to dohoff removal

Nonepileptic seizures

- Symptoms began concurrently with declaration to die by starvation
- IV benzodiazepines and anti-epileptic drug regimens
- Neurology team consulted
- Rather than correlating with medical events, these correlated with social events
- Curiously associated with the 1:1 sitter present by her bedside
- Blink to threat
- Jokes
- During symptoms, primary team monitored from afar
- Lack of reinforcement caused all symptoms to spontaneously cease

Discussion & guidance

- Factitious disorder is difficult to diagnose
- Literature suggests physicians to establish a timeline⁹
- Cardinal signs to recognize include: inconsistencies in the history, symptoms that appear out of proportion to presenting pathology, refusal to disclose records, and self induced findings
- Ms. L intentionally engaged in harmful behaviors to be hospitalized: based on historical information, her self report, and results from medical testing
- Literature suggests outpatient management as main setting for treatment of FD
- However, Ms. L engaged in destructive behaviors that precluded her discharge for outpatient management
- FD results in significant expenditure of money; Ms. L incurred significant costs with prolonged hospital stay
- Her care required specialist care multiple times
- In addition to the monetary costs, Ms. L generated significant emotional toll on her treating teams
- There were often disagreements between the primary team and the consulting teams, and at times need for involvement of hospital ethics committee
- Her management demonstrated not only the financial, but also the ethical and emotional challenges that FD imposes on caregivers
- At the forefront of this conflict is the caregiver’s desire to maintain beneficence
- Beneficence is challenged by a patient who we perceived, regularly, to manipulate us
- At what point does gentle confrontation of the patient become the forefront of treatment?

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