

## The Great Pretender

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### Case Presentation

A 56 year-old female from Pennsylvania presented to a Toronto hospital with a one-month history of nausea, vomiting, diarrhea and suprapubic pain, and a two-week history of bilateral flank and lower back pain. She reported a urinary tract infection (UTI) of three months' duration, for which she had seen three physicians: the first prescribed ciprofloxacin (Cipro); the second prescribed ampicillin (Ampicin) after cultures grew *Enterococcus*, and the third prescribed nitrofurantoin (Macrochantin). On examination, the patient was afebrile, with moderate bilateral costovertebral angle (CVA) tenderness and dry mucous membranes. She had mildly elevated serum sodium (149mmol/L, range 135-145mmol/L) and blood urea nitrogen (12.7mmol/L, range 2.5-7.0mmol/L). Fecal occult blood was detected, and her urine dipstick was positive for ketones. CT scan showed narrowing of the rectum and sigmoid colon and deep ulceration of the distal sigmoid, suggestive of inflammatory bowel disease.

The patient was rehydrated and given intravenous vancomycin (Vancocin) for possible antibiotic-resistant *Enterococcus* pyelonephritis, and oral vancomycin for possible *Clostridium difficile* colitis. Oral vancomycin was chosen over metronidazole (Flagyl) because the latter could have a therapeutic effect on Crohn's disease and confound interpretation of the planned sigmoidoscopy. The patient requested a peripherally-inserted central catheter (PICC), citing poor venous access and injection pain; her request was granted.

The patient's symptoms improved, although she continued to experience diarrhea. Urine and blood cultures showed no microbial growth, while *C. difficile* toxin was detected in stool. Sigmoidoscopy revealed normal mucosa. Intravenous vancomycin was discontinued due to the absence of findings suggestive of UTI or pyelonephritis. The patient protested this treatment change angrily. Soon thereafter, the patient complained of worsening flank pain, nausea and vomiting. Intravenous vancomycin was recommenced, and the patient reported swift improvement of her symptoms.

The team suspected that the patient was fabricating symptoms in order to receive intravenous vancomycin. History and physical were repeated. The patient could remember neither the names of previous physicians, nor the towns in which she had been treated. She declined to provide family contact information. She reported that each dose of vancomycin gave her immediate relief, and that symptoms would return near the end of each dosing interval. Flank palpation elicited a delayed expression of pain. On abdominal palpation, the patient appeared to feign vomiting.

The patient was told that vancomycin would be discontinued. She then confessed that she had been lying since admission and that she had fabricated her history and symptoms of pyelonephritis, but that her reported diarrhea on presentation was real. She said that she had a "kidney infection" of

three years' duration, and that intravenous vancomycin was the only drug to provide relief. She had been hospitalized multiple times in her efforts to receive vancomycin, being told each time that she had no infection. She had been told by one physician that she had Munchausen syndrome. Hospitals in Pennsylvania and surrounding states eventually refused to admit her. She then sought care in England, where similar hospitalizations occurred. She finally travelled to Toronto in order to seek intravenous vancomycin.

The patient asked to remain in hospital to receive a "complete" course of intravenous vancomycin, which would render her "good for six months." Her request was denied. She refused to be seen by psychiatry. The patient was discharged with oral vancomycin sufficient to complete therapy for *C. difficile* colitis.

**What is the differential diagnosis of the patient who expresses physical symptoms yet has no organic illness?**

The differential diagnosis includes malingering, factitious disorders, somatoform disorders, and delusional disorder.

Malingering is the intentional production or exaggeration of signs or symptoms, and is motivated by external incentives such as avoiding work, obtaining drugs, or delaying prosecution.<sup>1</sup> At times, malingering may be considered adaptive: for example, the battered woman who fakes illness to earn the safety of admission.

Factitious disorders are those in which patients simulate or self-induce illness in order to assume the sick role. These patients are conscious of feigning, but unconscious of their motivation for doing so. Malingerers, in contrast, are aware of their motivation for feigning. Whereas malingering may be adaptive, factitious disorders are always pathologic. Patients may simulate symptoms or self-induce signs (e.g. instilling blood into the bladder to produce hematuria) or illness (e.g. injecting insulin to induce hypoglycaemia). Munchausen syndrome is a severe and chronic factitious disorder with three cardinal features: recurrent hospitalization, peregrination (traveling widely to receive care), and pathological lying.<sup>1</sup>

Patients with somatoform disorders experience physical symptoms in the absence of organic pathology. In contrast to factitious disorders and malingering, the symptoms are experienced as real. Somatization may mimic almost any organic pathology, but more common presentations include somatization disorder (historically coined hysteria: characterized by multiple physical complaints, especially pain and gastrointestinal, sexual or neurological symptoms); conversion disorder (loss of motor or sensory function); and hypochondriasis (preoccupation with the fear of having serious disease, based on misinterpretation of bodily symptoms).<sup>1</sup>

Delusional disorder is a psychosis in which patients experience non-bizarre delusions without marked impairment in

psychosocial functioning. Common somatic delusions include insect or parasite infestation and the emission of foul odours. Tactile hallucinations (e.g. itch) may be prominent. Delusional disorder differs from hypochondriasis in that hypochondriacs hold their beliefs with less-than-delusional intensity.<sup>1</sup>

#### What is the diagnostic approach to such patients?

Diagnosis may be difficult or impossible. Patients feigning illness are notoriously unreliable and uncooperative historians, and the sophistication of their presentation is limited only by the extent of their medical knowledge. Often, patients whose deception is revealed deny the allegations and/or rapidly discharge themselves.<sup>1</sup> Furthermore, many of these disorders are associated with psychiatric comorbidity, so cases may be complicated by mood, anxiety or personality disorders.<sup>1,2</sup> These and other factors make these patients hard to manage and the prevalence of these conditions difficult to estimate. Despite the frustration of managing these patients, the cost of medical care as well as the potential for litigation and/or mortality behoove the physician to be diligent in diagnosis and careful in management.<sup>3,4</sup> The diagnostic approach requires the clinician to answer three questions:

1. Does the patient have organic disease that can explain the presentation?

Ruling out organic disease must be a decision of exclusion and may be very difficult. Careful history taking and physical examination, as well as thorough investigation and progress monitoring are essential. Clues that aid in diagnosis include inconsistent or implausible findings, negative or atypical test results, and the failure of treatment to result in improvement. Clinicians must remember that factitious symptoms do not preclude coexisting organic disease.

Patients' behaviour may aid in the diagnosis. Patients with factitious complaints may present with facility with medical jargon and readiness to undergo invasive procedures. They may also anger easily, deny clinicians' efforts to gather data, and receive few visitors and phone calls.<sup>1</sup> Features suggestive of somatoform illness include female gender, multiple complaints, anxiety, and physician identification of the patient as "difficult".<sup>1,5</sup> Delusional disorder usually has a late age of onset, and may be more common in patients who have relatives with schizophrenia or paranoid personality traits.<sup>1</sup>

**Back to the case:** On admission, this patient had physical and laboratory findings consistent with volume depletion due to diarrhea. Diagnostic workup was negative for pyelonephritis, but did reveal *C. difficile* infection, illustrating the iatrogenic morbidity that can befall career patients. The *C. difficile* infection probably delayed the discovery of her factitious complaint. Once staff felt that *C. difficile* could not entirely explain her presentation, history and physical exam were carefully repeated: history taking revealed a highly improbable "relief" from each dose of vancomycin and physical examination elicited feigned pain and nausea. The patient's behaviour had also raised suspicions: her apparent inability to remember the names of prior physicians and hospitals from which she had received treatment, her refusal to provide contact information, and her anger on discontinuation of vancomycin caused staff to question the veracity of her

complaint. Ultimately, her confession confirmed the team's suspicions.

2. Is the patient intentionally producing the signs or symptoms?

The presence of feigning or intentionally-produced illness suggests either factitious disorder or malingering, and argues against somatoform disorders and delusional disorder. Occasionally, staff will find a "smoking gun" (e.g. a syringe of blood found under the patient's mattress) or exogenous substances in a patient's lab samples. In the absence of such clear indicators, clinicians must carefully piece together clues based on diagnostic workup and patient behaviour. A feigning patient may appear to be comfortable to nurses, yet affect symptoms in the presence of physicians. Clinicians can only hope for a confession from the patient.

**Back to the case:** This patient's confession of inventing a history and feigning symptoms strongly suggests either factitious disorder or malingering. Her presentation was cleverly crafted: the story of *Enterococcus* infection resistant to ampicillin, nitrofurantoin and ciprofloxacin persuaded the admitting physician to take the unusual step of prescribing empiric vancomycin for suspected pyelonephritis. Her recurrent hospitalization, peregrination, and lying suggest factitious illness of Munchausen-like severity. However, the diagnosis is confounded by the fact that the patient did not recant her statement about having a "kidney infection." It is thus possible that she suffers from delusional disorder that has driven her to great lengths to seek treatment.

3. Are external incentives motivating the patient's behaviour?

The identification of external incentives suggests in favour of malingering and against factitious disorder. Taking a psychosocial history from patients and their contacts may reveal motivations for their behaviour. Other features suggestive of malingering include antisocial personality traits and a history of medicolegal action.<sup>1</sup> Malingerers are typically reluctant to follow physicians' suggestions for investigation, while patients with factitious disorder often readily agree to diagnostic workup.<sup>6</sup>

**Back to the case:** The patient's evasiveness made it difficult to identify her motivation. Her eagerness for an invasive intervention (the PICC line) is typical of patients with factitious disorder and suggests against malingering. The patient attributed her behaviour to a desire for intravenous vancomycin therapy. Although drug-seeking malingering by opiate- or benzodiazepine-dependent patients is common, it is difficult to conceive of gratification inherent in vancomycin. There are no published reports of antibiotic-seeking leading to such efforts as were observed in this patient. Since the patient's confession may not have been entirely forthcoming, it is possible that she was motivated by another external incentive. However, her confession of recurrent hospitalization and peregrination suggests in favour of factitious disorder and against malingering.

#### What, then, is this patient's diagnosis?

This patient probably suffers from severe factitious disorder consistent with Munchausen syndrome. However, her

refusal of psychiatric consultation, her swift discharge after being discovered, and her general unreliability render the diagnosis uncertain. The patient's insistence that she suffers from kidney disease keeps delusional disorder on the differential diagnosis, and likewise her unreliability means that malingering cannot be ruled out.

### What is the management of a patient with factitious disorder?

There is no specific therapy for factitious disorder. For patients who refuse psychiatric care, guiding principles include trying to limit a patient to one physician and preventing unnecessary interventions.<sup>6</sup> "Difficult" patients often provoke hostility from health professionals;<sup>7</sup> educating health professionals about the disorder will help staff to recognize the pathology and impose appropriate limits on patients.

Whether to confront patients with evidence of fakery is controversial. Concerns about confrontation provoking suicidal behaviour have not been borne out in practice.<sup>8</sup> There is some consensus that confrontation may be effective when done by the attending physician and psychiatrist together, when it is not retaliatory and when it is followed by an offer of psychiatric treatment.<sup>6</sup>

Patients' prognoses appear to depend on the severity of the disorder. In general, patients with chronic or bizarre presentations are refractory, as are patients with significant psychiatric comorbidity.<sup>6</sup> Several behavioural therapies have been employed, but there are few reports of successful psychotherapeutic management. Pharmacotherapy directed at coexisting anxiety or depression may have a beneficial result.<sup>9</sup>

**Back to the case:** This patient's management resulted in a suboptimal outcome, as the patient did not engage in psychiatric therapy. Had a psychiatrist been present during confrontation, the patient might have been persuaded to participate in a psychiatric consultation. During her stay, the patient provoked hostility from the healthcare team: staff were glad when she confessed and were relieved to see her discharged. Hostility towards such patients reduces the chance of a therapeutic alliance and may impair clinical outcomes.

The patient was discharged with a prescription for oral vancomycin. The team was uncomfortable continuing this "psychologically loaded" antibiotic, especially since the sigmoidoscopy had been normal. However, CT scan on presentation had showed narrowing and ulceration of the rectosigmoid; it is possible that the sigmoidoscope did not enter far enough to visualize mucosal lesions, or that lesions had healed in the days between the CT scan and sigmoidoscopy. The team was reluctant to switch to oral metronidazole on discharge because the patient was unlikely to follow up with care. Finally, the patient had been informed that oral vancomycin has no therapeutic effects outside the gastrointestinal tract.

### Conclusion

This case illustrates some of the diagnostic and therapeutic difficulties presented by the dissembling patient. Awareness of somatic presentations of non-organic disease will help clinicians to minimize the morbidity and mortality of this spectrum of disorders.

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