Hypertensive Crisis Secondary to Factitious Disorder

To the Editor: Factitious disorder is a form of feigned illness in which the patient provides false information and behaves deceptively but has no other incentive for the behavior other than to be a patient and experience the sick role.[1] Factitious disorder may vary from slight symptom exaggeration to the extreme form called Munchausen syndrome, which is often accompanied by impersonation and fabrication, sometimes with serious risk to life. Factitious hypertensive crisis is extremely rare, difficult to diagnose, and often leads to extensive workup and utilization of enormous amounts of money, resources, and time. We report the case of a patient with hypertensive crisis who underwent extensive workup before receiving a diagnosis of factitious disorder.

Case report. A 40-year-old white man with self-reported history of hypertension and chronic kidney disease stage IV (secondary to hypertension) presented to the emergency department (ED) multiple times and was admitted 3 times over 3 months for hypertensive crisis. He reported several hospitalizations in another state for hypertensive crisis. During the initial ED visit, his blood pressure was 240/130 mm Hg. He required 7 days of hospitalization for blood pressure management and underwent extensive workup. He was discharged on 6 medications (nifedipine XL 90 mg daily by mouth, carvedilol 25 mg twice daily by mouth, lisinopril 40 mg daily by mouth, spironolactone 25 mg daily by mouth, furosemide 40 mg twice daily by mouth, and clonidine 0.3 mg/24-hour patch). One month later, he was referred to the ED from the outpatient clinic for high blood pressure (240/148 mm Hg) and required 8 days of hospitalization to control his blood pressure. He was discharged on 9 antihypertensive medications (clonidine patch 0.3 mg/24 hours, furosemide 80 mg twice daily by mouth, lisinopril 40 mg daily by mouth, nifedipine XL 90 mg daily by mouth, spironolactone 50 mg daily by mouth, isosorbide mononitrate 120 mg daily by mouth, prazosin 2 mg twice daily by mouth, labetalol 600 mg twice daily by mouth, and minoxidil 20 mg twice daily by mouth) with blood pressure in the 140/90 mm Hg range. Ten days later, he presented again to the ED with a blood pressure of 242/148 mm Hg. After initial stabilization, he was admitted to the medical floor. By the 24th day of hospitalization, he was taking the following medications: amiloride/hydrochlorothiazide combination 5 and 50 mg daily by mouth, carvedilol 25 mg twice daily by mouth, nifedipine 60 mg every 8 hours by mouth, minoxidil 10 mg every 8 hours by mouth, lisinopril 40 mg daily by mouth, clonidine 0.4 mg every 8 hours by mouth, furosemide 60 mg every 8 hours by mouth, A-methyldopa 500 mg every 8 hours by mouth, and hydralazine 100 every 8 hours by mouth, but his blood pressure was still high.

He was seen by a treatment team from the internal medicine, nephrology, cardiology, and endocrinology departments. Multiple tests to rule out secondary hypertension were inconclusive. His baseline creatinine level ranged from 3 to 3.5 mg/dL with glomerular filtration rate approximately 20 mL/min. The biochemical workup was within normal limits except for one very elevated norepinephrine level (8,497 pg/mL) during his first hospitalization, which normalized in repeated laboratory assessments. Hormonal workup results were negative for other catecholamine excess, aldosterone, or cortisol excess. Metaiodobenzylguanidine nuclear scan showed increased activity in the left adrenal gland, but repeated noncontrast computed tomography and magnetic resonance imaging (MRI) of the chest and abdomen over 6 months were normal. The multidisciplinary team felt that he did not meet criteria for pheochromocytoma. Aortic coarctation and renal artery stenosis was ruled out by MRI and duplex doppler vascular study. Renal ultrasound showed mildly increased renal echogenicity with subtle cystic changes. A transthoracic echocardiogram was inconclusive.

During his third hospitalization, pills were found in his bathroom, underneath the bed, and in a dustbin. He persistently denied noncompliance and became annoyed when asked to take pills under direct nursing supervision. Thereafter, the psychiatry department was consulted for malingering. During the initial psychiatric evaluation done with his wife (a hospice registered nurse) present, he denied noncompliance. However, when interviewed alone, he admitted to throwing pills away for no specific reason. He denied doing this for attention or relief of stress and reported some trouble expressing himself in words. He denied any childhood trauma. Recent life stressors included financial issues and non-Hodgkin's lymphoma in a son treated 6 months ago. He reported some sadness and anxiety due to his hypertension and he felt comforted by the sick role he assumes. He was diagnosed with factitious disorder (*DSM-5* criteria) and provided brief supportive psychotherapy after which he started taking his medications. His blood pressure stabilized, and he was discharged on lisinopril only.

This case fulfils some of the criteria for factitious disorder, a psychiatric condition in which a person deliberately creates or exaggerates illness symptoms in several ways. These patients do not want to achieve a clear benefit of treatment but have an inner need to be seen as ill or injured. Our patient was deliberately medication noncompliant with no desire to achieve any treatment benefits. People with factitious disorder may be aware of the seriousness of self-harming behavior, but they are unable to control their compulsive behavior. When confronted with proof of their self-harming behavior, they often deny it and refuse psychiatric help. Patients with factious disorder often appear more comfortable than their "disease" warrants during hospitalization and are receptive to all recommendations for evaluation and procedural intervention irrespective of involved risk. However, they may become enraged or even physically threatening when questioned or doubted. Depression and anxiety are frequent comorbidities.

The cause of factitious disorder is unknown. However, people with the disorder may have experienced severe illness during childhood or may have been emotionally or physically abused, which causes isolation and feelings of insecurity, leading to dissociative personality disorders as a primary defense mechanism and promoting self-harm behavior as a way of dealing with traumatic events. Other risk factors include a relative with serious illness; a poor sense of identity; low self-esteem; loss of a loved one through death, illness, or early life abandonment; unfulfilled desire to be a health professional or work in the health care field; and personality disorders.[2,3]

Only a few cases[4,5] of hypertensive crisis due to factitious disorder have been reported in the literature. Although hypertension is not always suspected as a feigned symptom, providers should be suspicious if patients present repeatedly with hypertensive crisis despite being on multiple antihypertensive medications, expose themselves repeatedly to invasive tests despite normal results, and are reluctant to provide past medical

history. Major effort should be made to obtain the previous medical records, and suspected patients should be treated under direct supervision. Early recognition of such patients and timely psychiatric intervention can save enormous amounts of money, resources, and time. Maintaining a registry of diagnosed cases of factitious disorder may help in preventing the unfavorable consequences.

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