When the Labs Don't Add Up:

Factitious Disorder and Successful Treatment

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Factitious disorder (FD) is a condition in which patients knowingly deceive others by appearing ill, impaired, or injured without obvious external reward. FD disproportionately affects women (66.2%)[1] and impacts 1%–2% of the US population.[2] FD is estimated to cost the US health care system $40 million/year; however, this figure is likely an underestimate due to the challenges in diagnosing and reporting FD accurately.[3] FD requires clear evidence that a patient is intentionally fabricating symptoms, and the absence of overt illness-inducing behavior makes the diagnosis challenging. Furthermore, research is limited on differing management strategies for FD. We describe a case that demonstrates successful long-term treatment of FD and highlights the complexities of diagnosing and managing this disorder.

Case Report

Ms H is a 37-year-old woman with a history of a congenital atrial septal defect, recurrent supraventricular tachycardias, postural tachycardia syndrome, seizure disorder, and iron deficiency anemia with port placement. Following a week of nausea, vomiting, and diarrhea, Ms H presented to the emergency department (ED) with recurrent syncope and acute kidney injury. Chart review revealed that she was hospitalized a month ago with similar symptoms and diagnosed with digoxin toxicity, and her home digoxin was discontinued. However, upon current hospitalization, a detectable digoxin level of 1.2 ng/mL (0.8–2.0 ng/mL) was observed despite reported discontinuation (half-life = 36 hours). This level increased to 1.3 ng/mL the next day despite fluid resuscitation. Toxicology consultation ruled out alternative explanations, suggesting active digoxin ingestion, potentially even during hospitalization.

The inpatient team's primary physician, with whom the patient was already established as her outpatient primary care physician (PCP), consulted psychiatry. Ms H denied psychiatric symptoms, interpersonal or financial stressors, or a history of trauma. She was diagnosed with FD, and intensive outpatient follow-up with her PCP was recommended to avoid the misuse of medical resources. Four days after discharge, she met with her PCP, who made deliberate attempts to control the patient's FD with frequent visits and limited medical workup. Over the next 20 months, Ms H was seen in the clinic biweekly.

Prior to outpatient involvement, the patient was seen in the ED every 1.6 months. These visits included concern for pyelonephritis, myalgias, dizziness, bacteremia, and dyspnea. After biweekly PCP follow-up, the average length of time between ED visits increased to 3.3 months, with no recorded concern for FD.

Discussion

Ms H's case is a clear demonstration of the challenges that FD can present to the health care system. It is rare to have objective data for FD; however, the patient's rising digoxin levels amid reported discontinuation and toxicology consult provided clear evidence that the patient was engaging in factitious behavior. Our case is consistent with the typical FD demographic, as she was female, in her mid-30s, and worked in health care.[1] Unusually, cardiac FD presentations are more likely to be falsely reported, rather than induced as in our case.[1] This case represents a data point in favor of extensive outpatient monitoring. While Ms H did not engage with outpatient psychiatry, she was compliant with biweekly PCP visits, resulting in a significant decline in resource utilization.

Given that previous studies have elucidated FD's poor prognosis,[3] clinicians can be limited in management strategies. Psychotherapy is recommended; however, getting patients to agree to therapy can be challenging, as confrontation often provokes more elaborate manipulation or discontinuation of care.[4–6] While medications may be warranted in treating comorbid psychiatric conditions, they have not proved efficacious for FD alone.[7] This case demonstrates that, while highly involved, close PCP follow-up can be effective at reducing the cost that FD places on EDs and inpatient physicians.

Conclusion

FD is a complex condition to diagnose and manage. A nonconfrontational strategy with primary care coordination may represent an effective approach to caring for FD patients.

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