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When the Labs Don't Add Up: A Case of Factitious Disorder Diagnosis and Management

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BACKGROUND

- **Factitious disorder (FD)** requires evidence that the **patient is provoking symptoms**.
- C-L psychiatrists frequently assist with care. Convincing symptoms with **rare objective evidence** make diagnosis challenging. (Jimenez 2020)

CASE

- Ms. H: patient in 30's with postural tachycardia syndrome (PoTS), epilepsy, iron deficiency anemia, and GAD.
- Admitted for hypotension, syncope, and acute kidney injury with reported nausea, vomiting and diarrhea. **Hospitalized 1 month prior for the same** and diagnosed with **digoxin toxicity,** which was discontinued.
- On admission: **detectable digoxin level (1.2) despite reported discontinuation**; digoxin level was 0.4 (0.8-2.0 ng/mL) 1 week prior. Digoxin discontinued again. Level increased (1.3) the next day despite fluid administration, suggesting further digoxin doses - Toxicology stated other explanations unlikely.
- **Other inconsistencies**: reported epilepsy with undetectable levetiracetam levels despite reported adherence, reported thalassemia with negative electrophoresis, reported PoTS without objective data, and anemia of unclear etiology.
- On psychiatric consultation: Anxiety endorsed in the context of illness, denied acute psychosocial stressors.
- Factors that increased concern for FD: **medical job, receiving healthcare in multiple states,** and **eagerness to undergo medical interventions.**
- Ms. H was diagnosed with FD **but not confronted** with diagnosis. The **medical record now includes the FD diagnosis** and **toxicology's recommendations** for specific labs when she re-presents with symptoms.

Factitious Disorder Management Strategies

(**No consensus** on best approach)

STRATEGY	CASE CONSIDERATIONS
Supportive confrontation + Psychotherapy follow-up	• Higher potential for loss to follow-up as patient had history of seeking healthcare in multiple states. • Patient previously stated lack of desire for psychotherapy
Non-confrontation + Outpatient medical follow-up + Treating comorbid psychiatric conditions	• Potential for missed opportunity to connect patient with definitive treatment without confrontation • Higher likelihood of patient remaining engaged in care

Figure. Two potential management strategies for FD and considerations with Ms. H. The lower strategy was ultimately chosen.

DSM-5 – Factitious Disorder Imposed on Self

1. Physical or psychological symptoms are falsified, or disease/ injury inflicted
2. Person presents themselves to others as ill, impaired, or injured
3. Deceptive behavior is evident even in the absence of external rewards
4. Behavior is not better explained by another mental disorder such as delusional or psychotic disorder

* DDx somatic symptom disorder, malingering, functional neurological disorder, borderline personality disorder
* Associated with psychological distress and functional impairment

DISCUSSION

- There is not enough evidence to support any one FD management strategy (Eastwood 2008).
- This case's approach involved careful documentation and avoidance of confrontation, keeping Ms. H engaged in outpatient care and reducing unnecessary hospitalizations. She continues to see PCP weekly, unusual in that many patients are lost to follow-up (Bass 2014).
- **Cardiac FD presentations** are **more likely falsely reported or feigned**, rather than induced (Yates 2016). It is rare to have objective data for FD, as was available here with digoxin levels.
- More research is needed. A **non-confrontational strategy with coordination between healthcare teams** may represent an effective approach to caring for FD patients. **C-L psychiatrists** play an important role in **developing effective management strategies** across the spectrum of care.

REFERENCES