

Case report

A case of factitious disorder presenting with hematohidrosis: a rare case report

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Summary

Factitious disorder is described as the patient's intention to produce fake symptoms to play a sick role and gain medical attention.¹ The symptoms could be physical, psychological or mixed. The wide spectrum of symptoms makes the diagnosis and management challenging. This is a case report of a 17 year old girl who was referred to us with history of recurrent bleeding from left side of her forehead. Detailed hematological investigations revealed no abnormal causes of bleeding but on clinical examination, we found multiple scar marks on the affected site. The history was suggestive of hematohidrosis but the patient had scar marks on the affected area which indicated that the bleeding was self-inflicted. This was the most important diagnostic and differentiating point in this patient. Pharmacotherapy and psychotherapy were followed by complete remission.

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Introduction

Factitious disorder presents with patients intentionally producing symptoms to assume sick role. According to DSM-5 diagnostic criteria for factitious disorder imposed on self, include faking physical or psychological signs or symptoms, or inducing self-injury or disease to deceive others into believing that he or she is ill, impaired or injured. This deceptive behavior has no external gain such as monetary or avoiding any legal responsibility.² It can result in multiple hospitalizations with needless investigations and invasive diagnostic procedures that may have worrisome side effects. Differential diagnoses that are usually ruled out include malingering, somatic symptom disorder and anxiety disorders.³ The main differentiating point in factitious illness is to gain the sick role whereas the goal in malingering is to gain rewards, such as compensation, or to avoid the unwanted, such as military service or jail.⁴ The predisposing factors for factitious disorder include adverse health conditions in childhood or adolescence for which continuous treatments and hospitalizations made them dependent and developed bitterness towards doctors, preexisting mental conditions like depression or personality disorder.⁵ History also reveals that often patients suffering from this disorder have been left abandoned and/or experienced physical or mental and emotional abuse in childhood.⁶ Confrontation and psychotherapy is the common treatment given in factitious disorder. Hematohidrosis, also known as hematidrosis, is a rare clinical condition where a person presents

with sweating of blood. Psychogenic cause, such as extreme stress is found to be the most frequent cause among other causes such as systemic disease and vicarious menstruation.⁷ Here we present a case of a young girl with symptoms of hematohidrosis which later through thorough history taking and clinical findings was found to be a case of factitious disorder, which is rare.

Case report

A 17 year old unmarried girl was referred to National Institute of Mental Health, Dhaka with the complaint of recurrent bleeding from the left side of her forehead for 3 months. The bleeding was preceded by headache which started with a pressure around the head. It was not associated with aura or vomiting, persisted for 20 to 30 minutes, subsided with spontaneous bleeding and was followed by post headache amnesia. Each episode of bleeding started from the same side and persisted for about 4 to 5 minutes. Every time about 5 to 6 ml of frank blood was shed. Her family members occasionally observed that her mental condition transformed to an altered state where she appeared to be possessed. According to her, someone or something that she could not see but only feel, entered her body and tried to have sex with her. She stated that she experienced this multiple times, after which she lose her consciousness. When she comes to her senses, she would find herself naked with her clothes kept beside her and she could never properly recall what happened with her. Sometimes this event preceded

the headache. There was no history of fever, oral ulceration, photosensitivity, hematemesis, melena, epilepsy or taking any anticoagulant or antiplatelet drugs. There was no history of psychiatric illness in the family. Her childhood however was very difficult. At an early age, she lost her father. Her family faced lot of financial issues and her mother had to struggle to run the family. Being the youngest sibling, she always felt she was ignored by her brothers and her mother always prioritized her brothers according to her. Even at school she did not have any close friend, spoke very less with her classmates and spent most of her time at home. She never shared her feelings with her family, friends or relatives. On mental state examination, the patient was well kempt and groomed, with no odd motor or social behavior. Her speech was relevant but her mood was depressed. She avoided eye contact throughout the interview and kept her gaze was downwards. There was no thought or perceptual disturbance. Her cognitive function was intact and had insight that she had a medical condition which required treatment and was admitted in the hospital willingly. Detailed general and systemic examinations as well as routine hematological and neurological investigations could not explain the cause of the bleeding. The overall clinical picture was suggestive of hematohidrosis. Few days after her admission, when the patient again had bleeding, clinical examination was repeated. Multiple cut marks were seen at the site of bleeding which were well defined, not too deep from the surface of the skin and smooth, which made us suspicious that whether it was self-inflicted. This was the most important diagnostic and differentiating point for this patient, as because if this was self-inflicted, then our diagnosis will take a completely different turn. We asked the attendant of the girl to carefully notice how the bleeding starts and if it occurs in their absence or presence. Pharmacotherapy was started with fluoxetine and cognitive behavioral therapy was given. Multiple family therapy sessions were taken to identify any conflict with family members and resolve them. The main conflict was that the girl had very low self-esteem and felt unloved and uncared for by her family members. She often got upset with her mother when she talked about her marriage and financial issues with her brothers. Her brothers often told her mother to discontinue her studies. She felt like she was a burden in the family. Follow up was given after 2 weeks. When she came back during follow up, her brother informed us that before taking her home, they removed all sharp objects including razors and blades from the house. On thorough searching, they found a blade under her bed and removed it. The incident did not repeat again after that. A few days before the follow up, she suddenly displayed extreme aggression and her mother and brothers saw she was running around her room searching for something. Her bed mattress was turned upside down and her books were thrown on the

floor. When they asked her why she made a mess of her room and if she is looking for anything, she started to cry and act like she was being possessed. Regular follow up and psychotherapy for 6 months improved her condition and the incident did not repeat again.

Discussion

Multiple psychological theories attempt to explain the motivation and thought process behind the voluntary production of symptoms in factitious disorder which include disruptive childhood, personal identity conflicts, somatic illness as a form of masochistic activity towards oneself, and intra psychic conflicts.³ According to experts, patients with factitious disorder are much more likely to have suffered from a difficult or traumatic childhood. A study on factitious disorder found that out of 57 members, only 3 described having a good childhood while the rest had various forms of emotional and physical abuse.⁸ In case of this girl, loss of her father at an early age, followed by a struggling childhood decreased her self-esteem. She was also an introvert, kept her feelings inside and did not share her problems with her family or friends. Presentation of factitious disorder can be physical, psychological or both. Our patient had both features, physical was bleeding from forehead and psychological was that she was possessed. The first conflicting point in this patient was her physical symptom where she claimed that the bleeding was spontaneous. This symptom correlated with hematohidrosis, which is oozing of blood from intact skin under conditions of extreme stress. Complete physical examination revealed injury and scar marks in the affected area which excluded hematohidrosis. Further history taking and on follow up visit, she confessed that the bleeding occurred by self-induced trauma with blade. This brought two differential diagnoses in our mind, either malingering or factitious. Malingering was ruled out as there was no secondary gain or avoidance of any unwanted situation. Our second conflicting point was possession of an unknown within her. This brought a third differential diagnosis, dissociative disorder, where possession is a common presentation (14.55%).⁹ But as the girl did this to obtain medical care along with to increase her acceptance in the family, which is the characteristic feature of factitious disorder, dissociative disorder was ruled out. Behavioral explanations for factitious disorder are that it is the result of social learning and reinforcements. By faking symptoms of being sick, she got attention and care, gained sympathy and compassion from her family members which served as positive reinforcement in continuing her illness.¹⁰

Conclusion

Diagnosis of factitious disorder is very challenging. It comes with variable presentations which delays diagnosis. Studies reveal that some patients of factitious disorder may actually have co-existing physical disease or another psychiatric disorder

which should be ruled out.¹¹ Proper knowledge about the disorder and intuitive understanding is necessary for early diagnosis and better outcome of this disorder. The prognosis of factitious disorder is poor and the actual treatment is still under debate. Hence, we need more studies and case reports on factitious disorder.

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