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Case Report

Epistaxis: An Uncommon Presentation of Factitious Disorder

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ABSTRACT

Factitious disorder with physical symptoms is a psychiatric disorder in which an individual deceives others by appearing sick, purposely getting sick or self-injuring. This was a case report of a 22-year-old married woman who was referred to us with a history of headache, nasal bleeding and unconsciousness as a primary clinical manifestation of a factitious disorder, which was diagnosed and treated after further investigation and psychiatric consultation. In this case report, the purpose was to raise the issue of psychiatric problems and their importance alongside physical problems, especially epistaxis.

Keywords: *Epistaxis, Factitious disorder.*

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INTRODUCTION

Factitious disorder is considered to be a mental disorder characterised by a non-authentic, feigned symptom presentation either in the form of a voluntary production of symptoms (for example, self-inflicted injury, artificial fever, self-induced wound healing disturbance) or a false, misleading or grossly exaggerated symptoms report (DSM-5)[1]. About 1% of psychiatric consultations are concerned with a factitious disorder[2]. The key criterion of factitious disorders is described as a falsification of physical or mental symptoms (instead of false presentation), and it extends to the induction of injury or disease. It is different from malingering, where the person lies for a clear motive such as money, drugs or avoiding work. Sick role behaviour leads to hospitalisation and unnecessary diagnostic and therapeutic interventions. Sometimes the induction of symptoms leads to severe complications and even death[3]. Therefore, identifying these patients and referring them to psychiatric services is essential in recognising the symptoms and preventing severe complications[4].

The case was unique because very few epistaxis cases were reported as a primary clinical manifestation of a factitious disorder, which was diagnosed and treated after further investigation and psychiatric consultation. Multidisciplinary therapy was recommended with cognitive behavioural therapy and antidepressant medication to treat frequent comorbid depression, anxiety or stress.

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CASE REPORT

This case report described the history of a 22-year-old married woman residing in Mira Bazar, Sylhet was referred to the psychiatry department from the otolaryngology department of Jalalabad Ragib-Rabeya Medical College

Hospital with complaints of headache, bleeding from the nose (epistaxis) and history of unconsciousness several times. She showed blood on tissue paper when she returned from the washroom. Her family members occasionally observed that her mental condition transformed into an altered state where she was feeling stressed. The patient had no history of psychiatric or medical illnesses such as hypertension, coagulation or bleeding problems, or taking any anticoagulant or antiplatelet drugs. She was referred to the psychiatry department through the otolaryngology department, where detailed general and systemic examinations as well as routine haematological investigations, including kidney function, liver function, thyroid function, blood platelet count and coagulation factors tests, were performed that could not explain the cause of the bleeding. According to the nursing report, during the hospitalisation period, the patient had epistaxis three times a day when she went to the washroom. Finally, after a week of her admission, she left the hospital with some improvement, but her stress sustained. But after one week, the patient got admitted a second time with the same complaints. In addition to previous steps, clinical examination was repeated, and X-ray paranasal sinuses occipito-mental view were performed, and the results showed normal. No active or passive bleeding point was found on examination of nose conducted by the otolaryngologist. But the patient insisted on staying at the hospital for more diagnostic confirmation. Thus, the otolaryngologist gave the nursing staff instructions to oversee the patient's care and keep an eye on her behaviour. He also got permission from the patient to schedule a mental health consultation. On mental state examination, the patient was well 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 downwards. There was no thought or perceptual disturbance. Her cognitive function was intact and she had insight that she had a medical condition that required treatment and was admitted to the hospital willingly. Initially during the interview, she refused to disclose any information. Finally, she disclosed the main conflict that she was not comfortable with her husband because she was not in a close emotional and psychosexual relationship with him as her husband was suffering from schizophrenia. Her mother also described that her daughter’s relationship with her husband was aberrant. We asked the patient to notice carefully how the bleeding started and if it occurred in the presence or absence of her attendant. She said that she collected blood on tissue paper by injuring her gum with a sharp pin and mixing it with nasal secretions, which simulates epistaxis. That’s why she had no active or passive bleeding point on the nose. With the primary diagnosis of factitious disorder, pharmacotherapy was started with escitalopram 10 mg/day and quitiapine 25 mg/day with supportive psychotherapy sessions arranged in the psychiatry department. Multiple family therapy sessions were taken to identify the conflict with family members and resolve it. There was no secondary gain or benefit for the patient, and finally she was discharged from the hospital with the diagnosis of factitious disorder and advised to continue psychotherapy sessions by the psychiatrist. Follow up was given after two weeks. When she came for follow-up, her mother informed that they had resolved her conflict. The incident did not repeat after that. Regular follow-up and psychotherapy (cognitive behavioural therapy) for a year improved her condition. She was no longer hospitalised as her problem was resolved.

DISCUSSION

Due to the complexity of the diagnosis of a factitious disorder, it was always one of the most challenging issues among physicians, especially psychiatrists[5]. Ultimately, these processes would have an extra burden on the patient’s health system[6,7]. Multiple psychological theories attempted to explain the inspiration and thought process behind the voluntary production of symptoms in factitious disorder, which included intrapsychic conflicts. The presentation of a factitious disorder could be physical, psychological, or both. Our patient had both features. The physical was bleeding from the nose and headache, whereas the psychological was that she had conflict. The first conflicting point in this patient was her physical symptom, where she claimed that the bleeding was spontaneous. The symptom correlated with epistaxis, which was the oozing of blood from the nose under conditions of extreme stress. The patient was complaining of epistaxis, but a detailed clinical examination revealed no active or passive bleeding point on the nose but the patient had a bleeding point on the gum which indicated that the bleeding was self-inflicted. Further history taking and follow-up visits revealed that the bleeding occurred by self-induced trauma, and haematological investigations revealed no abnormal causes of bleeding. This was the most important diagnostic and differentiating point in this patient. Pharmacotherapy followed by psychotherapy was helpful for complete remission of those symptoms.

This brought two differential diagnoses in our mind, either malingering or factitious disorder. Factitious disorder was differentiated by a tendency for more diagnostic and therapeutic investigations and also no secondary gain from the treatment[8] or avoidance of any unwanted situation or unsolved conflict.

In general, factitious disorder was more common among

females[9] and it could be stated that in this case, gender and conflict played a key role in the patient's sick role behavior. In this study, the patient wanted more attention from her parents, physicians, and staff.

Furthermore, the patient did not resist any diagnostic procedure but insisted on further investigations. It should be noted that in such patients, all medical conditions should be carefully investigated and ruled out. In this case, all laboratory tests related to the initial clinical symptoms and thorough physical examinations and consultation with other specialists were carried out. Finally, when the disorder was ruled out, the role of psychological factors were taken into consideration. Social learning and reinforcements were behavioural explanations for factitious disorders. By faking symptoms of being sick, she got attention and cared and gained sympathy and empathy from her family members, which served as positive reinforcement in continuing her illness.

CONCLUSION

Proper knowledge about the factitious disorder and intuitive understanding are necessary for early diagnosis and a better outcome of this disorder. The prognosis of factitious disorder is poor, and the actual treatment is still under debate. Resolving conflict through psychotherapy was the life-changing treatment for this patient. Hence, we need more studies and case reports on factitious disorders.

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