Malingering, conversion and factitious disorders. The emotional and monetary costs to the healthcare delivery system

Dear Editor,

We would like to describe the case of a 30 year old otherwise healthy but obese Caucasian lady who was admitted to our hospital on two occasions separated by about four months. The admitting diagnosis was low back pain. The patient did give an underlying history of depression and anxiety and was on treatment for this. An MRI of the lumbosacral spine was performed prior to the first hospitalization revealed mild left-sided L5 S1 foraminal stenosis. The patient’s hospitalization was remarkable for a physical examination that lacked consistency. The patient required high doses of narcotic analgesics. She was subsequently discharged and evaluated by psychiatry. Electrophysiological studies performed on an outpatient basis did not reveal any evidence of a radiculopathy. The patient was then readmitted to this facility for excruciating low back pain. An MRI of the lumbosacral spine performed with and without contrast did not reveal any new abnormality. The patient again required high-dose narcotic analgesics and was scheduled for discharge after the weekend. Immediately prior to discharge, the patient developed acute onset flaccid paralysis of the right lower extremity. The exam, however, was non-physiologic and reflexes were preserved. Lumbosacral MRI was repeated and, additionally, that of the thoracic spine was performed with and without contrast to rule out a disc herniation, osteomyelitis-discitis, an epidural abscess, malignancy or demyelination. This was done on a stat basis and routinely scheduled patients were moved around at great inconvenience. This was negative. Neurology was consulted and further MR imaging of the brain and the cervical spine was ordered. The former was negative. The latter revealed an acquired superimposed on congenital cervical spinal stenosis with a left paracentral C4-5 disc herniation indenting the left side of the spinal cord. However, a cerebrospinal fluid stripe could be seen dorsal to the spinal cord on sagittal T2-weighted imaging. The MRI of the cervical spine did not explain the patient’s clinical condition. She was subsequently evaluated by our physical/occupational therapists and psychiatrists. A diagnosis of a conversion disorder was offered.

Ideally, the diagnosis of a psychiatric disorder should only be offered after ruling out an organic pathology, regardless of how bizarre the initial presentation may be. When this pertains to the nervous system, extensive craniospinal imaging and/or a spinal tap may be needed. It has been our experience that an initial clinical impression of a non-physiological examination due to a malingering/conversion/factitious disorder has almost always proven to be correct. However, medicolegal requirements dictate an extensive and prolonged workup. The costs to the healthcare system are enormous as is the emotional fatigue suffered by the caregivers. The patient above decided to challenge her healthcare providers’ competence by demanding a transfer to another facility and a second opinion. Current etiquette dictates that patients not be told that ‘they are faking it’ or that ‘it’s all in their head.’ This caution can backfire. A few aggressive patients can sense this reticence and along with unwitting family members they can demand to know why they are afflicted by profound neurological deficits in the presence of normal imaging. When confronted with no clear answer, often times, rather cruel aspersions can be cast on the competence and judgment of the hospital staff. This is truly a delicate condition and requires multidisciplinary care. During her hospitalization, the hospitalist, neurology, neurosurgery, psychiatry and rehabilitation services were consulted as was the regional tertiary care hospital regarding the patient’s request for transfer which was ultimately and not unexpectedly rejected.

Mental health issues dominate our current medical landscape. It is important to recognize that the difference between malingering, a conversion disorder and a factitious disorder is the goal or the intent of the patient. Malingering patients desire secondary gain such as workman’s compensation, damages through liability suits or a furlough from jail. Patients with a conversion disorder do believe that their illness is ‘real.’ There is no gain. Factitious disorders manifest typically as a Munchausen syndrome with the desire to play the role of a patient. The primary gain is the acquisition of sympathy and emotional support. Munchausen by proxy generally involves pediatric victims who often require frequent hospitalization for myriad medical illnesses.

Although it is important to be aware of intent from a diagnostic point of view, the consequences are significant emotional and monetary costs to the
health care delivery system. The care of such patients can be extremely fatiguing and demoralizing to the healthcare team which is trained to deliver, almost always, the goal of better physical health.

The prevalence of malingering or a factitious disorder in patients presenting to the hospital is about 1.3% according to a crude estimate[1]. Despite a low prevalence, the cost of in hospital admission, imaging, and unnecessary testing is significant, and varies from case to case[2]. Apart from the obvious financial toll, malingering puts the life of the patient at risk due to exposure to various procedures and medications. Additional resources such as legal representatives, ethicists and psychologists may be needed to address the medicolegal nuances that invariably follow.

There are no current guidelines in managing these complicated patients and this represents a pressing need. It has been our experience that awareness of these conditions and clear communication between members of the care team is essential so that everyone speaks the same gentle yet firm language. An option exercised by some healthcare providers involves ‘being fired’ by the patient. We would strongly recommend against this strategy as this sets up other members of the care team for an even harder time at the hands of an even more irate patient and the family. This may have longer term consequences and can engender an adversarial outlook which may cloud future patient-physician relationships with suspicion and result in missed organic diagnoses.

Disclosure statement
No potential conflict of interest was reported by the author.

References
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