A Man with Nails and Needles Inside: A Case Report of Factitious Disorder

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Received 2018 October 14; Revised 2019 January 4; Accepted 2019 August 23.

Abstract

Introduction: In factitious disorder (Munchausen syndrome), patients induce or aggravate symptoms of physical or psychological illness to receive attention and medical treatment. The motivation of these patients is merely getting a sick role and medical care, and entering the medical system; most of these patients have simultaneous mood disorders (especially depression), or personality disorders. Patients with factitious disorder have no secondary gain.

Case Presentation: Herein, we present a middle-aged Azerbaijani man from Sarab city, East Azerbaijan who referred to hospital with complaints of abdominal and leg pain. Based on examinations, he had undergone repeated surgical procedures (laparotomy and surgical removal of the external object from the leg) due to the presence of a foreign body (needle and nail) in the intestines and leg’s calf. The interview was done based on DSM-5 by a psychiatrist and after a two-month follow-up, the diagnosis was affirmed by a second opinion through a ground round session at the department of psychiatry, Tabriz university of medical sciences, Tabriz, Iran. He is under treatment with an SSRI along with cognitive psychotherapy.

Conclusions: Patients with atypical and unusual manifestations of an illness associated with frequent hospital admissions and receiving multiple therapies can lead us to the diagnosis of a factitious disorder. Although patients often deny their disease and evade treatment, he was ultimately diagnosed with factitious disorder and received psychiatric treatment. The treatment goal is to reduce mortality and morbidity and to treat the underlying psychiatric disorder.

Keywords: Factitious Disorder, Munchausen Syndrome, Self-Injury, Foreign Bodies, Needle Ingestion

1. Introduction

Patients with factitious disorder induce, develop, or exaggerate disease symptoms to get medical attention. These patients may impose painful and even life-threatening injuries without the aim of receiving external rewards such as avoiding tasks or financial gains. The main clinical manifestation of factitious disorder is a falsification of physical or psychological symptoms or induction or exaggeration of injury or disease without any clear gain or external reward (1). The actual prevalence of the factitious disorder is unknown, although it is estimated to be approximately 1% of the health-seeking population. In fact, the estimation of the actual prevalence of this disorder had methodological limitations (2).

Most patients have experienced working in medical or nursing professions. Further, many patients are from crowded families who may have been neglected in their childhood and have grown without adaptive coping skills. Accompanying psychiatric disorders such as major depression, substance abuse, psychiatric disorders, or mental retardation may be seen in these patients. Therefore, cognitive and psychoanalytic treatments and treatment of the underlying psychiatric disorders are advised in these patients (3). Behavioral theories also suggest that patients receive a positive reward by playing the role of a patient, who receives care and attention, not provided at home or from the medical system and this system acts as a source of emotional support and care. In treating patients with factitious disorder, the main three general objectives include: reducing the risk of morbidity and mortality of the patients, finding the underlying emotional needs or underlying psychiatric diagnoses, and addressing the ethical and legal issues of the patients (1).

In this article, a middle-aged Azerbaijani man from Sarab city, East Azerbaijan is presented who had frequently referred to general hospitals with complaints of abdomi-
nal and leg pain. According to examinations, he had under-
gone repeated surgical procedures (laparotomy and sur-
gical removal of the needle from the leg) due to foreign 
bodies (needle and nail) in the intestines and leg. Medical 
examination was otherwise normal. There was no sign of 
acute abdominal pain and no GI bleeding was revealed during 
the follow-up studies. The interview was done based on 
DSM-5 by a psychiatrist and the diagnosis was affirmed by 
a second opinion through a ground round session at the 
department of psychiatry, Tabriz University of Medical Sci-
ences, Tabriz, Iran. The objective is to emphasize the impor-
tance of timely diagnosis and treatment of factitious 
disorder to prevent invasive therapeutic and diagnostic in-
terventions and thereby, reducing the complications, mor-
bidity and mortality in the patients and preventing unnec-
essary diagnostic and therapeutic interventions. As it is a 
rare condition, it will be helpful for residents and medi-
cal students so that they pay more attention in the similar 
cases with limited treatment responses.

2. Case Presentation

The case was a 48-year-old married man, with 3 chil-
dren, a hospital employee who had undergone several pre-
vious surgeries after the diagnosis of foreign bodies inside 
the intestines and leg muscles. He was born in a crowded 
family with conflictual parenting and poor effective rela-
tionship with his siblings except for his younger brother 
who was committed to helping him get better. The patient 
was hospitalized in spring 2016 due to a traumatic injury 
to the left hand’s thumb (pressed by the door), with the po-
tential for finger amputation. A few months after this tra-
matic event, in July 2016, he referred to the hospital with 
complaints of abdominal pain and no bowel function and 
underwent laparotomy and treatment of the possible in-
testinal obstruction.

Two months after the laparotomy, in September 2016, 
the patient referred to the hospital again with complaints 
of abdominal pain, which was investigated by abdominal 
radiographies and underwent laparotomy surgery due to 
foreign body in the intestines (3 needles and 5 knitting nee-
dles). In March 2017, the patient underwent laparotomy 
again with the diagnosis of a foreign body (needle and 
nail inside the intestine). Eight months later, in November 
2017, the patient referred to the hospital with a complaint 
of pain and burning in the right leg’s calf. In the radiog-
raphic examination, the presence of a knitting needle in 
the right leg was diagnosed as the cause of the complaint 
and he underwent surgery for removal of the foreign body. 
During the recent year, the patient has been hospitalized 
repeatedly in a short period of time and therefore, the med-
ical staff suspected that the patient develops symptoms by 
swallowing knitting needles and nails and pushing need-
dles into his leg’s muscle; thus he was referred to a psychi-
atrist, although he declared he did not know why a needle 
 existed in these areas and denied it.

By interviewing the patient’s family, it was revealed 
that the patient complained of a balance disturbance and 
failing during walking without physical injury about 2 
years ago, and by referral to a neurologist and conduct-
ing EEG and brain MRI studies, there was no finding in fa-
vor of neurological lesion or seizure, and eventually the 
possibility of conversion disorder was considered for the 
patient. During this period, the patient suffered from re-
duced mood, symptoms of depression, and sleep disorder. 
In psychological examination with the Minnesota multi-
phasic personality inventory-2(MMPI-II), depression, mul-
tiple psychosomatic complaints, self-doubt, immaturity, 
and dependence were reported. In Thematic Appercep-
tion Test (TAT), the patient’s responses were elementary 
and simple, and he had a little abstract thinking, and most 
of the responses were related to depression. Rorschach 
test showed that the patient often had painful emotions, 
depression, and poor reality testing without psychotic re-
response.

The patient used denial, acting out and suppression 
defense mechanisms through interviews threatening to 
leave therapy. No psychosis was found in the investiga-
tions. On physical examination, the patient had multiple 
scars due to abdominal laparotomy as well as scars of surg-
eries in his legs in which the wounds were infected because 
of manipulations by the patient (Figures 1-4).

The patient was born in a crowded family and is cur-
rently a hospital staff with depressive disorder; all of these 
are risk factors of factitious disorder and it is possible that 
the patient was neglected in his childhood. For the treat-
ment of this patient, in addition to prescribing an antidep-
ressant (fluoxetine 30 mg daily) for the associated depres-
sive disorder, cognitive-behavioral therapy sessions were 
conducted to enhance coping skills with future stress. His 
family was reluctant to participate in family education ses-
sions. The only person accompanying the patient during 
follow-up visits was his younger brother. Proper manage-
ment of the factitious disorder, although is very difficult, 
could prevent unnecessary diagnostic and therapeutic in-
terventions in this patient and reduce the complications of 
frequent surgeries. A six-month follow-up showed a partial 
remission in depressive disorder and anxiety relief. How-
ever, he has now a favorite function in the work but the pa-
ient was unwilling to adhere to the treatment in the last 
visit. Intervention in his family system may require much 
more time than usual.
3. Discussion

Patients with atypical and unusual manifestations of a disease associated with frequent hospital admissions and receiving multiple therapies can lead us to the diagnosis of factitious disorder (4). In patients with factitious disorder, although the development of symptoms was conscious and intentional, the main motivation for the behavior of these patients for playing the sick role and receiving attention and medical treatment is unconscious (1, 2, 5, 6). The presence of depression, anxiety, traumatic experiences in childhood, or recent traumatic experiences in patients suggest the backgrounds for psychiatric disorders (1). Meanwhile, according to a study, patients with factitious disorder have lower depression, anxiety, and stress scores than individuals with open self-harm behaviors (7). The key point is that the patients may have masochistic or sexual incentives while inserting foreign bodies (8, 9). Based on psychiatric interviews, psychological assessments and information elicited from the informants, our patient has also presented unconscious motives from childhood period.

For diagnosis, there is no objective test available to confirm that symptoms of the illness are caused by the patients themselves, and on the other hand, the patients deny the symptoms and refuse psychiatric treatment, which makes it difficult to treat these patients. Working as a health care professional along with growing in a crowded family could make the presented case susceptible to fab-
Figure 2. AP radiography of the patient showed needle in both legs' calves

Figure 3. Laparotomy scars in the anterior abdomen are seen

Figure 4. The patient’s right leg indicating suture and surgical scars

Diagnosing of a patient with factitious disorder is challenging and needs a long-term monitoring and review of the past medical records which are denied by them. Other differential diagnoses such as conversion disorder and malingering should be kept in mind to be ruled out. In this patient, we did not find any external gain and while playing a "sick role" he had an unconscious motivation to fabricate the signs and symptoms claiming that his body was producing nails and needles.

One of the important factors in establishing a fair prognosis is early diagnosis and timely referral to a psychiatrist. The treatment cooperation between the patient and the doctor is one of the effective factors for improvement of prognosis, and therapeutic relationship between the physician and psychiatrist is essential in the treatment of underlying psychiatric disorders, such as depression or personality difficulties. Although the treatment of a patient with factitious disorder is very difficult, some cases have been treated successfully.

3.1. Conclusions

With the timely diagnosis of factitious disorder, it is possible to prevent invasive and unnecessary diagnostic and therapeutic interventions and reduce morbidity and mortality. In the patient introduced here, beside antidepressant therapy, used to treat the underlying depression, cognitive interventions, family therapies, and long-term psychotherapy was performed to provide appropriate treatment and prevent multiple surgeries and complications of laparotomy such as adhesion and intestinal obstruction. Although it is difficult to treat patients with factitious disorder, a therapist while making a strong alliance with them should primarily focus on co-morbidities and then family interventions and individuals’ psychotherapy as far as possible. The ultimate goal is to reduce complications, morbidity, and mortality in these patients.

3.2. Limitations

Although the clinical interview is considered the main procedure for establishing diagnosis, it should be clarified that self-disclosure is the limitation of our report.

Footnotes

Authors’ Contribution: Ali Reza Shafiee-Kandjani examined the patient and made the diagnosis. Somayeh Emamizad interviewed with the family and gathered the

Iran J Psychiatry Behav Sci. 2019; 13(3):e85352.
data. Mahmoud Farvareshi performed the psychological testings. Ali Reza Shafiee-Kandjani wrote the paper and all reviewed it.

**Clinical Trial Registration Code:** It is not declared by authors.

**Declaration of Interest:** The authors declare that they have no competing interests.

**Ethical Consideration:** An informed consent was obtained from the patient, and the anonymity and confidentiality was assured.

**Funding/Support:** The authors received no financial support for this case report.

**References**

1. Quinn DK, Wang D, Powsner S, Eisendrath SJ. Factitious disorder. In: Sadock BJ, Sadock VA, Ruiz P, editors. *Comprehensive textbook of psychiatry*. 10th ed. Philadelphia: Lippincott, Williams & Wilkins; 2017. p. 1846-64.

2. American Psychiatric Association. *Diagnostic and Statistical manual of mental disorders*. 5th ed. Washington, DC: American Psychiatric Association Publication; 2013. p. 324-6. doi: 10.1001/appi.books.9780890425596.

3. Catalina ML, de Ugarte L, Moreno C. [A case report. Factitious disorder with psychological symptoms. Is confrontation useful?]. *Actas Esp Psiquiatr*. 2009;37(1):57-9. Spanish. [PubMed: 18568454].

4. Sinha-Deb K, Sarkar S, Sood M, Khandelwal SK. Wires in the body: A case of factitious disorder. *Indian J Psychol Med*. 2013;35(2):209-11. doi: 10.4103/0253-7766.116258. [PubMed: 24049235]. [PubMed Central: PMC3775056].

5. Aydin E, Gokkoglu O, Ozcurumer G, Aydin H. Factitious cheilitis: A case report. *J Med Case Rep*. 2008;2:29. doi: 10.1186/1752-1947-2-29. [PubMed: 18226274]. [PubMed Central: PMC2266766].

6. Doherty AM, Sheehan JD. Munchausen’s syndrome—more common than we realize? *Ir Med J*. 2010;103(6):79-81. [PubMed: 20669802].

7. Fliege H, Lee JR, Grimm A, Pydrich T, Klapp BF. Axis I comorbidity and psychopathologic correlates of autodestructive syndromes. *Compr Psychiatry*. 2009;50(4):327-34. doi: 10.1016/j.comppsych.2008.09.008. [PubMed: 19486731].

8. Carney MW, Brown JP. Clinical features and motives among 42 artificial illness patients. *Br J Med Psychol*. 1983;56 (Pt 1):57-66. doi: 10.1111/j.2044-8341.1983.tb01532.x. [PubMed: 6838782].

9. Khan SA, Davey CA, Khan SA, Trigwell PJ, Chintapatla S. Munchausen’s syndrome presenting as rectal foreign body insertion: a case report. *Cases J*. 2008;1(1):243. doi: 10.1186/1757-1626-1-243. [PubMed: 18925957]. [PubMed Central: PMC2572607].

10. Repper J. Munchausen syndrome by proxy in health care workers. *J Adv Nurs*. 1995;21(2):299-304. doi: 10.1111/j.1365-2648.1995.tb01532.x. [PubMed: 7714287].

11. Zeshan M, Cheema R, Manocha P. Challenges in diagnosing factitious disorder. *Am J Psychiatry Resid J*. 2008;43(5):6-8. doi: 10.4176/ajprj.2008.110903.

12. Schwarz K, Harding R, Harrington D, Farr B. Hospital management of a patient with intractable factitious disorder. *Psychosomatics*. 1993;34(3):265-7. doi: 10.1016/S0033-3182(93)71889-7. [PubMed: 8493309].