AN ALTERNATIVE DIFFERENTIAL DIAGNOSIS: "FACTITIOUS URO-INTESTINAL FISTULAE"

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ABSTRACT

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Factitious disorder is described by the space representing unconsciously motivated but voluntarily produced physical or psychological symptoms. The essential feature of patients with this disorder is their ability to mimic physical symptoms so well that they are able to gain admission to and remain for prolonged periods in hospital. We report a 38 year-old woman with a rare form of factitious disorder in which gastric content is contaminated by drinking urine. Although contamination of a urine sample with various body fluids is a common method of malingering, to our knowledge, there is no reported case of factitious disorder in which gastric content is contaminated by drinking urine. Our purpose is to remind the physicians an alternative diagnosis in cases without any known organic origin and to show its considerable morbidity and even mortality.

Keywords: differential diagnosis, factitious disorders, fistula

ÖZET

ALTERNATİF BİR AYIRICI TANI: "YAPAY ÜRO-İNTESTİNAL FİSTÜL".

Yapay Bozukluk bilinçdışı ile motive edilen ancak istemli olarak üretilen fiziksel yada psikolojik belirtiler olarak tanımlanabilir. Bu bozuklukta hastaların önemli bir özelliği fiziksel belirtileri oldukça iyi taklit edebilmeleri, böylece hastâneye kabûl edilme ve hastânede çok uzun sürelerde kalabilmeyi sağlamalarıdır. Burada 38 yaşında bir kadın hasta da gastrik içeriğin idrar içerek kontamine edildiği nâdir bir olgu bildiriyoruz. İdrar örneklerinin değişik vücut sıvıları ile kontaminasyonu sık görülen bir hastalık taklidi olsa da, bildiğimiz kadarıyla gastrik içeriğin idrar içerek kontamine edildiği başka bir olgu bildirilmemiştir. Amacımız tıp çalışanlarına herhangi bilinen bir organik nedenin saptanmadığı vakalarda alternatif bir tanıyı hatırlatmak, bozukluğun ciddi morbidite ve hâttâ mortalitesini göstermektir.

Anahtar Kelimeler: ayrıcı tanı, yapay bozukluk, fistül

INTRODUCTION

Factitious disorder is described by the space representing unconsciously motivated but voluntarily produced physical or psychological symptoms (Taylor and Hyler 1993).

In factitious disorder, an individual feigns, exaggerates, or actually self-induces physicalor psychiatric illness to achieve ends such as mobilizing care and concern, ventilating aggression, diminishing guilty feelings, or gratifying dependency wishes (Feldmana et. al. 2008). It may involve any organ system. The physician assumes that the patient's complaints are caused by an undiagnosed disease and that a thorough history, physical examination, and appropriate tests will reveal the underlying medical disorder. The physician does not even usually consider that the patient has surreptitiously produced their symptoms or findings.

Once in the hospital, such patients are often demanding or difficult (Newmark et. al. 1999). Factitious disorders are associated with considerable morbidity and even mortality. Few patients accept psychiatric treatment; even fewer are cured (Wise and Ford 1999). After psychiatric evaluation and diagnosis, noncompliance with medical care is common, and these

patients frequently discharge themselves when the factitious nature of their illness is recognized (Gokturk et. al. 2008).

The purpose of this report is to present one of the largest barriers to diagnosis of a factitious disorder is the physician's and medical staff's utter disbelief that a person, especially a patient they "know" could do such a thing and to remind factitious disorders in cases without any known organic origin, as a differential diagnosis.

CASE REPORT

A 38 year-old woman was accepted to the chest diseases and tuberculosis clinic with complaints of spontaneous leakage of fluid from her mouth and coughing worsening at nights. The past medical history was unremarkable.

Physical examination and multiple laboratory tests including a complete blood cell count, chemistry panel, coagulation parameters, sedimentation rate, and arterial blood gases were all failed to disclose any relevant abnormality. Chest computed tomographic scan showed that there were linear atelectatic densities in posterobasal segments bilaterally. By means of full stomach computed tomography just an ovarian cyst was detected. Subsequently the patient underwent bronchoscopy which was reported as normal. According to intravenous pyelography, endoscopy, esophagus-stomach-duodenum graphy with barium, cystoscopy, ascending colon colonography, there was no meaningful finding. All autoimmune markers were negative. The culture and biochemistry test results of urine and the fluid were found similar. It was realized that the fluid was urine of the patient.

The origin of fluid coming from mouth was thought to be gastrointestinal system. The patient was consulted to the Gastroenterology Department. Endoscopy was applied again. No pathology was found. She was transferred to the urology clinic with the prediagnosis of urointestinal fistulae. Diagnostic laporotomy was applied. General surgeons and urologists assessed the patient together but the medical work-up failed to show any abnormality.

A psychiatric consultation was obtained and factitious disorder with predominantly physical signs and symptoms was diagnosed. Although she proclaimed an interest in receiving psychotherapy, she did not keep his follow-up appointment.

DISCUSSION

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition) diagnostic criteria for factitious disorder with physical signs and symptoms include the intentional production or feigning of physical signs or symptoms, and behavioral motivation to assume a sick role. There is also a lack of external incentives for behavior (Newmark et. al. 1999). There were no external incentives for these complaints, and therefore the case was differentiated from malingering (Yanık et. al. 2004). As it is demonstrated in our case, the patients were compelled, as it were, to produce additional symptoms in order to attract the serious attention of the physicians (Nordmeyer 1994).

In the literature urine is easily accessible, a medium that is downright tempting to patients interested in performing deceptive maneuvers with the aim of acquiring patient status. But the possibilities for feigning gastroenterology syndromes are fairly limited (Nordmeyer 1994). To our knowledge, there are no previous reports of factitious disorder in which urine is detected in the gastric content.

The essential feature of patients with this disorder is their ability to mimic physical symptoms so well that they are able to gain admission to and remain for prolonged periods in hospital [as in case summarized above]. To provide support for their histories, the patients are capable of feigning symptoms suggestive of a disorder that may involve any organ system. They are familiar with the putative disease, its diagnosis and course, the usual length of a hospital stay, and the overall outcome, and can give excellent histories capable of deceiving even the most experienced clinician. Furthermore it is known that prior experience in medicine gives shape to physical symptoms during factitious disorder in which our patient does not have any (Tlacuilo-Parra et. al. 2000).

When factitious disorder is suspected or discovered, immediate psychiatric consultation is recommended (Wise and Ford 1999). Although the diagnosis of this condition can sometimes take 6-10 years following onset, (Yanık et. al. 2004) our patient's early diagnosis is a distinguishing factor. The single most important factor in the successful management of these patients is the physician's early recognition of the disorder (Tlacuilo-Parra et. al. 2000). There is no specific effective treatment for factitious disorders (Taylor and Hyler 1993). Few patients accept psychiatric treatment; even fewer are cured. Firm approach is best accomplished by the primary physician and consulting psychiatrist working together (Wise and Ford 1999).

Factitious disorder is a chronic debilitating illness that is associated with considerable morbidity and

even mortality (Wise and Ford 1999). As in our case, it is usually diagnosed after many procedures. So an important societal impact of factitious disorders is the cost to the health care system. Several authors argue for the establishment of a regularly updated, readily accessible national registry of such patients to alert clinicians and facilitate early recognition (Baktari et. al. 1994).

CONCLUSION

In conclusion, we assert that there is a need for beter professional training in the recognition of this disorder. Also, in view of the high frequency of unexplained signs and symptoms in many other medical areas, future studies should examine factitious disorder estimations of physicians from other specific specialties, such as urology and gastroenterology. Factitious Disorders should be kept in mind as an etiological factor in cases without any known organic origin. More studies are needed to improve our understanding of factitious disorders' nature.

REFERENCES

Baktari JB, Tashkin DP, Small GW (1994) Factitious hemoptysis adding to the differential diagnosis. Chest; 105: 943-945.

Feldmana MD, Eisendrath SJ, Tyerman M (2008) Psychiatric and behavioral correlates of factitious blindness. Compr Psychiatry; 49: 159–162.

Gokturk HS, Demir M, Ozturk NA, Akkaya D, Yilmaz U (2008) Shifting opacities on plain abdominal radiographs: a rare case of factitious disorder. Med Hypotheses; 71: 468-470.

Newmark N, Adityanjee, Kay J (1999) Pseudologia fantastica and factitious disorder: Review of the literature and a case report. Compr Psychiatry; 40: 89-95.

Nordmeyer JP (1994) An internist's view of patients with factitious disorders and factitious clinical symptomatology. Psychother Psychosom; 62: 30-40.

Taylor S, Hyler SE (1993) Update on factitious disorders. J Psychiatryi in Medicine; 23: 81-94.

Tlacuilo-Parra JA, Guevara-Gutierrez E, Garcia-De La Torre I (2000) Factitious disorders mimicking systemic lupus erythematosus. Clin Exp Rheumatol; 18: 89-93.

Yanık M, San I, Alatas N (2004) A case of factitious disorders involving menstrual blood smeared on the face. J Psychiatry in Medicine; 34: 97-101.

Wise MG, Ford CV (1999) Factitious disorders. Primary Care; 26: 315-326.