

Otolaryngological manifestations of factitious disorders— a case and literature review

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Abstract

Otolaryngological manifestations of factitious disorders are rare. The case of a health care worker who injected her face and orbits with air in order to masquerade as facial cellulitis is presented. The literature and treatment strategies are reviewed.

Key words: Munchausen syndrome; Factitious disorders; Subcutaneous emphysema; Orbit

Case report

A 36-year-old female health care worker presented with a one-month history of recurrent episodes of swelling over her left face which followed minor facial trauma. The swelling increased with nose-blowing and was associated with decreased vision and fever.

Her past medical history included an ectopic pregnancy in 1954 (prior to her birth!) and a severe motor vehicle accident which resulted in scars over her anterior neck. Scars from venous cutdowns were present over every named vein. The patient was fluent with medical terminology and reported being allergic to penicillin, compazine, and iodine contrast. She refused to discuss her psychiatric history. Her father who was described as 'a fantastic pilot' had died in an air-crash in August 1990. The remainder of her history was non-contributory.

On examination, the patient was a tense woman of stated age. Her demeanour would change rapidly from being polite to unexplained hostility. Her initial tempera-

ture of 39.4°C decreased to 37°C prior to commencement of therapy. She had a diffuse left facial swelling which extended superiorly from the brow to the nasolabial groove inferiorly, and from the bridge of the nose medially to the malar eminence laterally. The skin over the swelling was tense, warm, erythematous, tender to palpation and crepitant. The left eye was proptotic with chemosis but without evidence of globe injury. Ocular pressures were normal. The left pupil was dilated, reacted sluggishly to

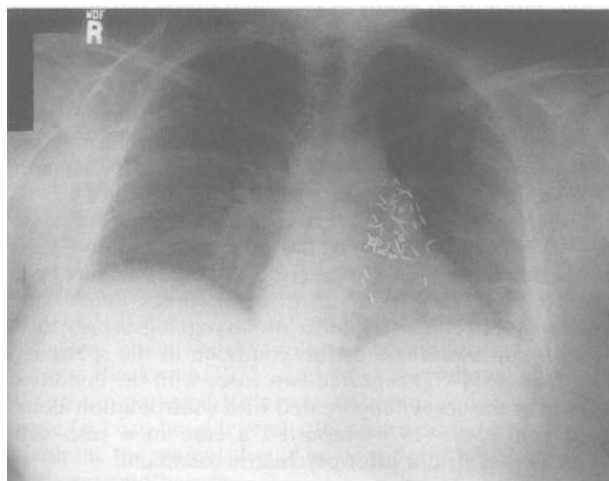


FIG. 1

Radiograph of the chest (postero-anterior projection) showing evidence of prior surgery.

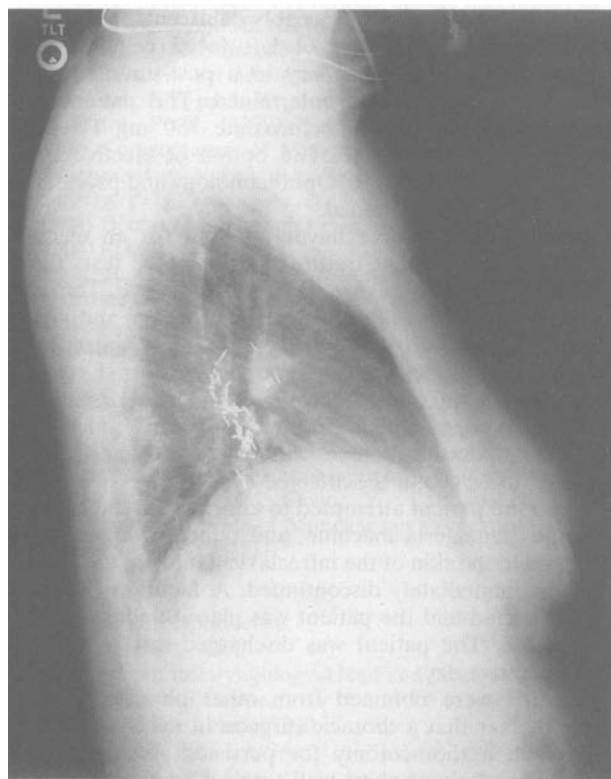


FIG. 2

Lateral radiograph of the chest in the same patient.

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FIG. 3

Axial CT scan demonstrating the presence of subcutaneous emphysema in and around the eyes on admission. This is more pronounced in the left eye. The questionable deficiency in the lamina papyracea (arrow) was not seen during surgery.

light, with a 20/70 visual acuity. The right eye was normal with visual acuity of 20/50. The patient demonstrated bilateral global ophthalmoplegia, but one of us (AKG.) observed the patient's eye track a nurse.

The patient had scars from a thoracotomy, an appendectomy, and a laparotomy. The WBC count was 10 000/mm³ without a left shift. A chest X-ray showed post-surgical changes in the hilum (Figures 1 and 2). On computed tomography (CT) scan surgical emphysema was evident bilaterally, both anterior and posterior to the septum orbitale (Figures 3 and 4). The lamina papyracea of both ethmoids was questionably dehiscent.

A provisional diagnosis of left facial cellulitis, and surgical emphysema secondary to a post-traumatic ethmoid sinus fracture was entertained. The patient was administered intravenous cefuroxime 750 mg IV q 8^h through a subclavian line. The option of elective sinus obliteration was discussed. Ophthalmology and psychiatric consultations were obtained.

After grumbling over having to wait for an elective operation the patient returned from the rest room complaining of very severe pain in the left eye. This was associated with an acute increase in proptosis and vision had diminished to light perception. The intraocular pressure was 21 mmHg. An emergency external ethmoidectomy and an orbital decompression was performed. The lamina papyracea and orbital floor were both intact. Her post-operative course was uneventful and vision returned to 20/400 in the affected eye.

When the patient attempted to tamper with the patient-controlled analgesia machine, and puncture marks were observed in the skin of the infraclavicular fossa, the central line was immediately discontinued. A factitious disorder was suspected and the patient was placed under constant supervision. The patient was discharged on the seventh post-operative day.

Records were obtained from other physicians which made it clear that a thoracic surgeon in another city had performed a thoracotomy for persistent pneumothorax and a non-resolving chest wall surgical emphysema, after the patient reported trauma to the chest. During that admission syringes and needles were found in the patient's possession, and no other cause for the pneumothorax could be detected. The patient had also been admitted to two other University Hospitals; on one occasion for

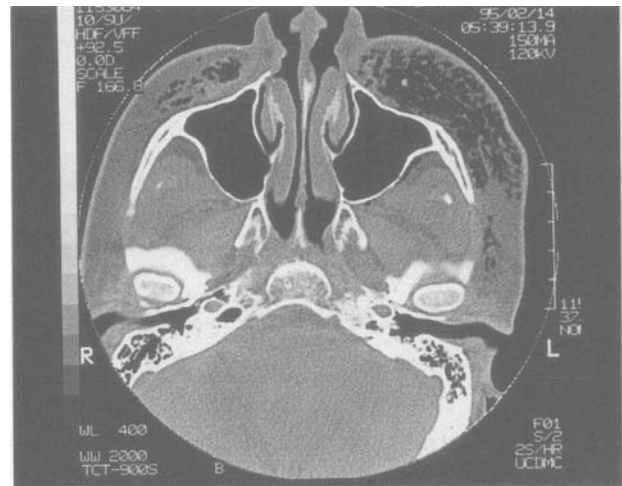


FIG. 4

A CT scan at a lower level demonstrates extensive surgical emphysema in the soft tissues over the malar eminence.

emphysema of the chest wall and at the other for orbital surgical emphysema. During one of these hospitalisations the patient had allegedly stolen and consumed coumadin from another patient. The probability of a factitious disorder was considered but never pursued.

Discussion

Munchausen's syndrome is a term that has the sanction of popular usage but is now referred to as a factitious disorder with physical symptoms in the DSM-III-R (American Psychiatric Association, 1987). It is characterized by the 'a) intentional production or feigning of physical (but not psychological) symptoms and b) a psychological need to assume the sick role, as evidenced by the absence of external incentives for the behaviour'.

Asher (1951) first described the condition, and dedicated it to Baron Hieronymus Karl Friedrich von Munchausen (1720–1797). An acquaintance of the Baron, Rudolfe Raspe in 1785 freely added his own stories, and published a successful book (Raspe, 1960), but the embarrassed Baron, portrayed as a raconteur of preposterous rather than mildly exaggerated stories did not suffer from the condition (Toth and Baggaley, 1991).

In addition to the protean clinical picture of abdomens crisscrossed with surgical scars, patients may present with haemoptysis, haematemesis, melaena, and haematuria, or fits, faints, headaches and anaesthesia (Asher, 1951). To this list were added 'dermatitis autogenetica' (Chapman, 1957) and 'hyperpyrexia figmentatica' (Spiro, 1968).

Otolaryngological manifestations of Munchausen's Syndrome are rare. Rhys Evans (1979) coined the term 'scophilia meanderans' to describe a patient who had been admitted a total of 38 times for endoscopies. Pender and Pender (1980) coined the term 'otolaryngologica prevarica' to maintain awareness of this condition in the speciality. Zohar *et al.* (1987) reported two cases with the condition who were unsuccessfully treated with confrontation alone. Patterson *et al.* (1974) reported a cure in a case with Munchausen stridor after psychiatric treatment.

Our case represents an extremely rare form of the malady. A similar case was reported by Winans *et al.* (1983), and Rosenberg *et al.* (1986). Their patient had to have an eye enucleated but was soon injecting the other eye with air. Akin to their patient, our patient was also a health care worker, had multiple prior episodes of air injection, and frequented hospitals along the west coast of

California. While we never did search her possessions, we are convinced that the patient used a syringe and needle as this alone could explain the presence of subcutaneous air in the absence of infection or orbital wall defect.

Patients with factitious illness consciously produce signs and symptoms of an illness although their motivation for doing so is unconscious (Eisendrath, 1984). This contrasts with hysterical conversion, hypochondriasis and psychogenic pain where both production and motivation are unconscious, and malingering where production and motivation are conscious.

Birch (1951) formulated a treatment strategy which suggested that these patients be blacklisted by hospital associations. Barker (1962) reported trials with hypnosis, insulin coma, electro-convulsive therapy and lobotomy but without long-term success. Eisendrath (1989) and Nadelson (1979) regard these patients as essentially untreatable. Hollender and Hersh (1970) developed a more sophisticated strategy with the primary physician confronting the patient in a non-punitive manner while the consulting psychiatrist avoid the prosecutor's role and try to help the patient understand the behaviour that the primary physician identified. We took this approach with limited early success.

The incidence of the condition is not known. It is estimated that 4,000 to 12,000 of these strange patients use U.S. hospital beds annually, incurring bills of up to \$40 million (Lawrence, 1991). This problem is underscored by the fact in an issue of the *New England Journal of Medicine* the same patient was reported by two different authors (Duffy, 1992; Ifudu *et al.*, 1992).

Based on confidentiality and ethical issues the creation of a data base for identification of such patients has been debated. Some authors believed that confidentiality is not inviolate when the doctor-patient relationship is distorted by the patient and the patient constitutes a risk to himself or herself (Duffy, 1993). Brown (1993) suggested that nothing justifies breaking the law and the patient's right to confidentiality. Until this issue is resolved it is our suggestion that these cases be reported at medical forums to alert other physicians about the possibility of the same patient coming to them for care. This will hopefully prevent the patient from getting harmed. Also clear mention of the condition being suspected or present must be made in the patient's chart.

Summary

Whenever discrepancy exists between symptoms, signs and laboratory findings, the possibility of a factitious disorder must be considered. While appropriate management of the organic condition must not be denied, early psychiatric intervention must be sought. It must be recognized that the condition is largely refractory to treatment, and the best chance of success is afforded by using a combination of confrontation while allowing for face-saving without being punitive. These cases must be discussed at medical meetings in order to alert other physicians about the possibility of encountering the same patient. Blackwell (1975) suggested the following axiom: 'When the personal history is elaborate and yet not one single fact can be independently corroborated by letter or telephone the patient should be considered a Munchausen until proven otherwise'.

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