Iran J Psychiatry Behav Sci. 2022 December; 16(4):e110238. https://doi.org/10.5812/ijpbs-110238.

Published online 2022 October 17. **Case Report**

Epistaxis: An Unusual Presentation of Factitious Disorder

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Received 2020 November 07; **Revised** 2021 December 27; **Accepted** 2022 September 16.

Abstract

Introduction: About 1% of psychiatric consultations are concerned with a factitious disorder. Unlike malingering, factitious disorder is a special psychiatric disorder that should be taken into consideration by the medical staff.
Case Presentation: This case reports a woman with fever and epistaxis as a primary clinical manifestation of a factitious disorder which was diagnosed and treated after further investigation and psychiatric consultation.
Conclusions: Procrastination of diagnosis usually leads to an increase in the length of stay for unnecessary clinical and paraclinical investigations. The purpose of this case presentation was to raise the issue of psychiatric problems and their importance alongside physical problems.

Keywords: Epistaxis, Psychiatric Consultation, Factitious Disorder, Malingering

1. Introduction

About 1% of psychiatric consultations are concerned with a factitious disorder (1). Factitious disorders in patients admitted to hospitals appear in two ways, with most of them showing physical symptoms and a few showing psychological symptoms (2). It should be noted that caregiving is the most important issue for the hospitalization of these patients (3). Unlike malingering, factitious disorder is a psychological disorder that should be taken into consideration by the medical staff (4).

Sick role behavior leads to hospitalization and unnecessary diagnostic and therapeutic interventions. Sometimes the induction of symptoms leads to severe complications and even death (5).

Therefore, identifying these patients and referring them to psychiatric services is essential in recognizing the symptoms and preventing severe complications (6).

This case reports a woman with fever and epistaxis as a primary clinical manifestation of a factitious disorder which was diagnosed and treated after further investigation and psychiatric consultation. The case is unique because very few cases report epistaxis as a primary manifestation of a factitious disorder.

2. Case Presentation

The patient was a 42-year-old single woman with a Bachelor's degree in English and working as an employee, with no history of psychiatric illness or medical illnesses such as coagulation or bleeding problems. She was admitted to the emergency department with complaints of fever, chills, and sudden nose bleeding (epistaxis). Medical investigations and a thorough medical examination were performed by an internal medicine specialist, including blood tests such as blood platelet count, kidney function, liver function, thyroid function, electrolytes, and blood coagulation factors. An infectious disease specialist was also consulted.

The results of all laboratory and coagulation tests were normal. According to the nursing report, during the hospitalization period, the patient had epistaxis attacks three times a day from the first day of admission. Sometimes without any medication, the patient's body temperature was normal, whereas sometimes, her body temperature increased to 38.5°C; despite the use of drugs such as acetaminophen and antibiotics prescribed by the infectious disease specialist, the fluctuation of the body temperature as well as the source of the fever remained unknown. Finally, after a week of her admission, she left the hospital complaining that the drugs were ineffective and that the medical personnel was not educated enough to treat her.

However, she returned to the emergency department the next week and was admitted to the ward with similar clinical manifestations. In addition to the previous steps, thorough abdominal and pelvic ultrasonography and chest X-ray were performed, and the results were normal. According to the thorough review conducted by the

physicians, the patient was reassured by the internal physician that she had no physical problems, but the patient insisted on staying at the hospital for more diagnostic investigations. The internal physician ordered direct supervision of the patient by the nursing staff to monitor her behavior in the ward.

According to the nursing report, the patient had taken a denture from her bag and was talking about it during the evening shift. She cried when the internal medicine physician asked about the denture. According to the patient, the denture belonged to her father, who had died suddenly and tragically two years ago in an accident. An internal medicine specialist requested psychiatric counseling despite the patient's desire. She initially refused to disclose any information but was later persuaded after speaking with the psychiatrist.

During the interview, the patient disclosed that even though she was still mourning her father, she did not have a close emotional relationship with him, and most of the time, he was not home. She also added that she had a closer relationship with her mother than her father (although the mother was not present during her hospitalization). Her mother was asked to attend the session for additional psychiatric history.

Her mother did not describe the relationship between herself and her husband as very good and acknowledged that she had been repeatedly beaten by her husband in front of the patient since childhood. She also described her relationship with her daughter as normal.

The patient denied any history of sexual and physical abuse, suicide attempts, or suicidal thoughts. On physical examination, there were no signs of self-injury on the limbs. With the primary diagnosis of persistent complex bereavement and the patient's consent, an antidepressant (fluoxetine 20 mg/day) was initiated, and supportive psychotherapy sessions (three times a week, each time 45 minutes) were conducted by psychiatrists in the internal ward. Although the patient initially was unaware of the cause of nasal bleeding, it was found during the psychotherapy sessions that she inserted a pin inside her nose, manifesting symptoms for hospitalization and obtaining medical care. There was no secondary gain or benefit description of the patient, and, finally, after three weeks of hospitalization, she was discharged from the hospital with the diagnosis of factitious disorder and was referred to a psychiatrist for continuing psychotherapy sessions. She continued her therapy (cognitive behavioral therapy) for a year, and while she was at it, she did not return to the hospital.

3. Discussion

Due to the complexity of the diagnosis of a factitious disorder, it is always one of the most challenging issues among physicians, especially psychiatrists (7). Procrastination of diagnosis usually leads to an increase in the length of stay for unnecessary clinical and paraclinical investigations. Ultimately these processes will have an extra burden on the patient's health system (8, 9). A factitious disorder may even lead to multiple unnecessary surgeries (10). Diagnostic or therapeutic interventions have even led to death in some cases (11). Meanwhile, subconscious and semi-conscious behaviors in these patients provide important clues for diagnosis (1).

In addition to clinical manifestations in this patient, i.e. epistaxis and fever as rare manifestations of factitious disorder, the disorder is manifested by symptoms such as neurological disorders, hypertension, skin rashes, hemoptysis, hematuria, and hypoglycemia (12-17).

The difference between factitious disorder and malingering is very important. Factitious disorder is differentiated by a tendency for more diagnostic and therapeutic investigations and also no secondary gain from the treatment (18).

The results of many studies have shown that rejecting parents play an important role in the psychosocial etiology of factitious disorder. Therefore, sick role behavior is used to re-create a desirable and positive parent-child bond. The disorders are a form of reputational compulsion, repeating the basic conflict of needing and seeking acceptance and love while expecting that these will not occur. Hence, the patient regards the physicians and the staff as rejecting parents (1). However, sometimes factors such as masochistic personality (in people undergoing multiple surgeries) as well as personality disorders such as borderline personality disorder can worsen the treatment prognosis (1).

In general, factitious disorder is more common among females (19) and it can be stated that in this case, gender and parental conflict played a key role in the patient's sick role behavior.

Another study also reported a case of unexplained epistaxis as a presentation of a factitious disorder. An 18-year-old girl presented to the surgical emergency department with abrupt onset bleeding from the nose. By injuring herself with sharp objects in unexposed areas and mixing them with nasal secretions, the patient simulates epistaxis. As we know, our case inserted pins into her nose, and both did so unconsciously to get more attention. The patient in that study wanted more attention from her parents, but in our case, maybe the patient regards the physicians and the staff as rejecting parents (20).

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 consulta-

tion with other specialists were carried out. Finally, when medical conditions are ruled out, the role of psychological factors should be taken into consideration. In the end, requesting psychiatric consultation will prevent any harm to patients and lessen the burden on the health system.

The purpose of this case presentation was to raise the issue of psychiatric problems and their importance alongside physical problems.

Acknowledgments

We thank our colleagues who provided insight and expertise that greatly assisted the research, although they may not agree with all of the interpretations of this paper.

Footnotes

Authors' Contribution: Writing and developing of the manuscript, Pezhman Hadinezhad; Patient management and other investigations, Mehdi Nasouhi, Pezhman Hadinezhad.

Conflict of Interests: There are no conflicts of interest.

Funding/Support: There was no funding or support.

Informed Consent: It was not declared by the authors.

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