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## Factitious disorder (Munchausen's syndrome) in oncology: case report and literature review

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### Abstract

**Background**—Factitious disorder is where patients repeatedly seek medical care for feigned illnesses in the absence of obvious external rewards; ‘Munchausen’s syndrome’ is the historical name for this disorder.

**Method**—We report on a case that was presented to a tertiary oncology center as a suspected rare bone cancer.

**Results and Conclusions**—Psychosocial clinicians working in oncology settings should be aware of the complexities of diagnosing factitious disorder in cancer settings where empathy is prominent and suspicion unusual. Moreover, comorbidity can cloud the diagnosis (in this case substance abuse), and, even when accurately diagnosed, there are no evidence-based management approaches to offer to the patient. What seems to linger most after the patient is discharged, usually in a huff, are strong counter-transference feelings and substantial medical bills.

### Introduction

Factitious disorder is where patients repeatedly seek medical care for feigned illnesses. Elaborate lies, claims of multiple medical problems, disruptive behavior, an inconsistent history, recent relocation, sophisticated knowledge of medical terms and an obvious need to assume a patient role with no evidence of other incentives or overt gain are characteristic of the disorder [1]. ‘Munchausen’s syndrome,’ the historical name for this disorder, is still in common use. DSM-5 divides factitious disorder into two subtypes: imposed on self, where an individual presents himself or herself as ill impaired or injured, and imposed on another, where a victim, often a child, is presented as ill, impaired or injured [1]. Patients may present with a variety of medical problems such as acute abdominal pain; hemorrhage; neurological deficits; symptoms of AIDS, renal, endocrine, cardiac, respiratory or

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dermatological problems; and, as in the case presented here, symptoms of malignancy. Childhood separations, emotional neglect or abuse [2], recent stressful life events, preoccupation with health, hypochondriac preoccupations, history of hospitalization in early childhood and severe instability in personal relationships are common associations [3].

Although the prevalence of factitious disorder is said to be 0.05–2.0% [4, 5], it is rarely seen in cancer settings. Therefore, the possibility of such a grand deception is hard for oncologists or psycho-oncologists to even consider.

The case in the succeeding paragraphs describes the typical muddle in which a diagnosis of factitious disorder finally crystallizes; its differential diagnosis and the way that multiple experienced clinicians were unable to identify the deception, despite their good intentions and superior clinical skills.

The discussion analyzes the case further in the context of the literature, the differential diagnosis, lingering diagnostic doubt and the lessons and costs for oncology and psycho-oncologists.

## Case

A 29-year-old woman with a one-year history of severe, persistent upper back pain in the hard-to-reach area between the upper thoracic spine and the medial border of the left scapula was referred to a tertiary cancer center. The referral was vague, and the patient provided the bulk of the history that also included a 40-lb weight loss over 6 weeks, hair loss (but no visible thinning) and vague upper gastrointestinal symptoms. There was no history of any injury or having had any malignancy. She had been extensively worked up by two tertiary care hospitals and treated by endocrinologists for adrenal insufficiency. Her last care provider was an orthopedic surgeon. Under his care, she was treated with T3 transforaminal and costovertebral blocks, which were ineffectual as were high doses of narcotics.

CT scan and MRI studies revealed changes consistent with a healing fracture of the third thoracic transverse process. Slight hyper-metabolic activity on a PET scan was also consistent with a sub-acute fracture, but the reported differential diagnosis included the vague possibility of a bone tumor.

She was convinced she had a malignant bone tumor despite being told by all her previous physicians that this was highly unlikely. Because of her persistence and in order to reassure her with cytologic confirmation, we agreed to do an excision biopsy of the transference process of T3.

Other stated past medical history included hypertension, tremor evaluated by two neurologists and a mitral valve abnormality, none of which were apparent on clinical examination.

Psychiatric history was stated as attention deficit/hyperactivity disorder, insomnia and anxiety. Developmentally, she described physical, emotional and sexual abuse by both parents between the ages 6 and 15 years, which only ended when she left home. She said

that she had no current contact with her nuclear family. She also said that she suffered from heavy metal toxicity called ‘Chinese drywall syndrome,’ for which she took an extensive list of over-the-counter chelating agents. Other medications included oxycontin, hydromorphone, amphetamine, clonidine, alprazolam and oral contraceptives.

Laboratory investigations including erythrocyte sedimentation rate, complete blood count, electrolytes, vitamin B12, folate, renal, thyroid and liver function tests were all within normal limits.

On mental status examination, the patient appeared seductive, wearing a purple tank top rather than the typical hospital gown. She covered herself to the neck with a sheet, when the examiner introduced himself as a psychiatrist. She wore makeup, with neatly groomed hair and seemed comfortable and pain free. Her affect was distant, but reactive. She seemed reluctant to engage with the examiner. A smile when describing ‘12/10’ pain seemed incongruous. Her thought content seemed superficial, highly defended and involved themes of trust versus mistrust. Cognitive parameters were normal.

Pathological examination of the resected left posterior third rib and T3 transverse process showed fibrosis and changes of remodeling, suggestive of a healing fracture without evidence of malignancy.

Post-operative course was significant for right lung collapse and lack of pain relief despite trials of several intravenous opioids at very high doses. Pathology was negative for malignancy. Increasing narcotic needs raised suspicion for abuse and caused counter-transferential feelings of anger toward the patient. The patient often declined or avoided psychiatry follow-up and disavowed the pathology findings insisting, ‘There is something terribly wrong.’ She also refused outpatient psychotherapy, rejecting the hypothesis that her symptoms had a psychosomatic etiology, perhaps related to her childhood trauma. How she fractured such as inaccessible area of her back remained a mystery; one hypothesis floated among the staff was that it was a self-inflicted hammer blow but there was no corroborating evidence to support this.

She had no visitors during her stay and no next of kin listed in her chart, but she frequently spoke on her mobile phone and received flowers from a godparent. She announced that she would return to her out-of-state orthopedic surgeon for further workup, but calls to this doctor were not returned. She left the hospital in a storm of harsh accusations on oral narcotics. The total cost of weeklong admission and surgery was around \$30,000.

## Discussion

Oncology centers are typically places of great kindness and compassion; clinicians who work there are dedicated and motivated. Imagine the visceral response to the dawning realization that all your efforts were voided by fraud and seduction. Disbelief and anger, and questions of whether the surgery was unnecessary were all present but unspoken. Politely labeled as counter-transference, these feelings toward patient and reactions of knowing that you have been deliberately misled can result in a strong desire to eject the patient as quickly as possible. Of course, in the case of the patient we have presented, professionalism

overruled this reflex, and the harder work involved discussing with the patient the complexity of the presentation and trying to help her deal with perceived physical dilemmas.

The differential diagnosis was debated. Was the patient simply drug seeking and therefore a diagnosis of malingering more appropriate? There seemed no obvious secondary gain apart from analgesia; on the other hand, which drug addict agrees to have part of his or her third rib and anterior process removed in the interests of getting narcotics?

The prominent lack of corroborating history also confounded the differential diagnosis. Was the history of sexual abuse by both parents true? Two-parent sexual abuse is rare [6] compared with the more frequent pattern of a related male predator. The patient had no visitors in hospital and listed no next of kin in the medical record. Psychiatry was unable to contact the referring physician, based on the information that she provided us, but orthopedics did speak to the referring physician pre-operatively. There was insufficient longitudinal data to substantiate a borderline personality disorder, although this was clearly also in the differential diagnosis. Similarly, the reported 'Chinese drywall syndrome' and 'heavy metal toxicity' raise concern for additional psychosomatic spectrum illnesses. Taken together, the unreliability of the clinical history created a serious diagnostic challenge because our usual medical model involves family-centered care where necessary diagnostic information is not withheld and certainly not falsified.

One factor that is not commonly considered in managing factitious disorder is medico-legal risk. These patients often undergo multiple, unnecessary life-threatening surgeries. Two deaths related to surgical complications have been reported [7]. In another case, the patient sued physicians because they administered treatment based upon a fabricated history [8]. Could this patient (or her family) sue the cancer center for wrongful surgery? If she was a psychiatric patient, but declined the psychiatric treatments offered to her, what was the duty of care in discharging her? Was there a risk of harm to her if she was to submit to further surgeries based on factitious symptoms and should involuntary hospitalization be considered, as one physician on the team in fact suggested? The psychiatric consensus was that she did in fact have capacity to make her own medical decisions, but there was significant discomfort in this assessment because of the self-harm that she in essence brought upon herself, either consciously or unconsciously.

A stepwise process, as suggested in Table 1, is helpful to reach the correct diagnosis of factitious disorder and to avoid the harm done by the unnecessary procedures and treatments. The detailed clinical interview with mental status examination followed by the comprehensive medical history from the family and previous physicians is key to a correct diagnosis. Relevant investigations, scans and biopsies should be reviewed by a second clinician or by a team approach. Ethics consultations; comprehensive case conferences; and safe, collaborative disposition plans are all helpful.

Similar published oncology factitious disorder cases also engender a sense of disbelief at good intentions betrayed: A 28-year-old woman and a 34-year-old woman sought bilateral prophylactic mastectomies by fabricating strong family histories of breast cancer [9]. A woman, aged 27, underwent operative insertion of a port-a-cath and multi-agent

chemotherapy for feigned advance ovarian cancer [10]. A 32-year-old man sought experimental therapy for metastatic adenocarcinoma of the urinary bladder with appropriated electronic medical records [11]. A 44-year-old woman sought imatinib therapy for chronic myeloid leukemia by falsifying medical records [12]. Fabricated records of allogeneic stem cell transplant resulted in a 23-year-old woman receiving intrathecal methotrexate [13]. A 60-year-old woman developed life-threatening bone marrow suppression, aseptic hip necrosis, transfusion-dependent thrombocytopenia and a chronic pain syndrome after being treated for recurrent deep ulcers resembling rare cancers. The ulcers were later confirmed as dermatitis artefacta—histopathology demonstrated traces of wood in the deeper scar tissues [14]. She later developed aplastic anemia after covert ingestion of oral busulfan and polymicrobial sepsis possibly secondary to the self-injection of feces into her central line. The total cost of care for the treatment of this patient's medical complications exceeded \$1,100,000 [15].

The aforementioned brief review of other published cases of factitious disorder in oncology raises the sensitive matter of who should pay for treatments caused by factitious disorders. In their paper, Powell estimated the cost of one patient who, during a 13-year period, spent 1300 days in a psychiatric unit, 556 days in prison and 354 days in medical care [16]. He made 284 emergency room visits and had 261 inpatient hospital admissions in total. The total assessable cost was \$695,000, which excluded the cost of police, ambulance, legal and social services, outpatient treatments, primary care and pharmaceuticals.

In the case presented, costs of a negative workup for malignancy were billed to the patient's insurance. Interestingly, a factitious disorder diagnostic code was not used because, until pathology returned as negative, there was always the possibility that this might be a rare cancer. Could an insurance provider be justified in rejecting payment? Will such cases be managed differently with new billing models that are outcome based or that penalize the provider for readmissions? Although factitious disorders are rare, it does not seem unreasonable that blacklists, central registers [17] and legal sanctions [18] proposed as possible management strategies might reemerge as a consequence of such newer billing models.

Blacklists raise fundamental ethical challenges to privacy and patient autonomy. One possible moral response is that, as the doctor-patient relationship is initiated by fraud, the privilege of confidentiality is not absolute and may be breached, as necessary, for the well-being of the patient and potential caregivers [19]. Moreover, there is a duty to communicate medical details efficiently between sequential providers so that future caregivers do not have to reinvent the wheel and rediscover afresh the pain of factitious disorder. Management could be timelier, diversion of valuable resources avoided and psychiatric treatment instituted earlier.

Involuntary compulsory treatment of such cases, however, seems difficult to justify [20]. One attempt involved a hospital's emergency department, physicians, social agencies, police, courts and emergency medical services who all struggled with a case for 17 months, but house arrest and court mandated treatment were all futile in containing the patient's acting out [21].

One reason why it is hard to recommend compulsory psychiatric treatment is that, even though it seems reasonable on one level, there is little research to indicate that psychosomatic medicine management approaches are effective. Some authors assert that recovery from factitious disorder is rare [22], but in truth, there are no well-designed longitudinal observational or interventional studies. Clinicians often report that it is very difficult to engage these patients in psychotherapy, and most patients seem to abandon the hospital system when confronted with facts [23], as was the case here. Perhaps because it is so rare, there are no tertiary treatment centers that such patients can easily be referred to, after the inpatient admission, as is the case with other rare medical conditions. Limiting potentially harmful and expensive investigations or procedures with close follow-up by one caregiver with good rapport is a common suggestion [24], but this is easier said than done. Electroconvulsive therapy and hypnosis, and, in earlier times, even insulin coma have been attempted without success [25].

One expert suggestion is to ‘expose and confront’ patients early after a plan for social and psychiatric care is arranged [10, 19]. The evidence should be presented to patients in a straightforward, non-accusatory, non-punitive manner, with the staff remaining sympathetic and emphasizing their continuing concern [26]. This was the approach used in the case we report. In retrospect, it seemed not to have been helpful, although not unreasonable either. There is, however, no published data, anecdotal or otherwise, not even a case series, to support this approach, which would in all circumstances represent the start of a longer psychotherapy.

There are reports that analytical long-term outpatient psychotherapy may be beneficial in promoting insight, diminishing self-directed negative feelings, and encouraging more mature coping [7, 27, 28], but the generalizability of these reports is unclear. It is improbable that our patient would ever have engaged in an analytic therapy. Integration of psychotherapy with antidepressants to improve dysphoria and low-dose antipsychotic drugs to diminish self-destructive behavior have been proposed [7], but these once again raise the issues of multi-axial comorbidity and the likely heterogeneity of patients with factitious spectrum disorders.

Early intervention by referring the patient to a psychosomatic medicine psychiatrist for evaluation would seem a prudent recommendation that might allow the medical system to react in a coordinated way [10], as this subspecialty is probably best trained to recognize it and manage the counter-transference reactions.

There remains an urgent need to formulate a cohesive approach to this rare syndrome. Much can be learned from oncology approaches to rare cancers that are studied through collaborative groups, and this strategy might be applied here. Practice guidelines issued by the Academy of Psychosomatic Medicine might be another worthwhile addition. A blacklist might be managed more ethically, under the auspices of research, but patients would have to in all circumstances consent to such. It is unclear whether newer psychotherapy approaches such as dialectical behavioral therapy, cognitive behavioral therapy, schema therapy, acceptance and commitment therapy and so forth could be adapted to treat this patient population.

In summary, oncology, with its culture of caring, is vulnerable to patients presenting with Munchausen's syndrome. Such patients also raise ethical issues that challenge traditional notions of privacy, beneficence, non-maleficence and the duty to care. Potential billing and medico-legal problems arise, and these are not helped by the lack-of-research-driven management approaches. Because it is rare, to further study this syndrome, psychosomatic medicine might well consider a collaborative group approach where patients are pooled, as is the case with rare cancers. Being deceived despite good intentions is a fate that is hard for physicians to swallow, and extensive discussion and case conferences are helpful to process the lies, manage the counter-transference and develop a plan of action. Psychosomatic medicine should lead this response.

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**Table 1**

## Steps for confirming a the diagnosis of factitious disorder

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1	The primary treating physician conducts an initial clinical interview and mental status examination, which raises the possibility of factitious disorder in the differential diagnosis
2	Collect a thorough collateral history from family, previous physicians and medical records
3	Conduct laboratory investigations to support the diagnosis of factitious disorder and eliminate other differential diagnoses
4	Consult with a psychosomatic medicine psychiatrist to crystalize a differential diagnosis and develop ethical treatment options
5	Conduct an inter-disciplinary case conference discussion to garner support for the diagnosis of factitious disorder and defuse counter-transference feelings resulting from the perceived deception
6	Institute a reasonable, rational and cautious treatment plan that spans inpatient and outpatient care and is shared in a collaborative way with the patient and staff
7	Evaluate the success of the management and treatment plan and the lessons learned

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