

REVIEW

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Insights into the clinical profile and comorbidities of Factitious Disorder in a multispecialty setting in southwest Nigeria: A cases series and review

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Abstract

Background: Factitious disorder (FD) is an under-recognized and under-diagnosed mental condition. Healthcare professionals often have challenges to diagnose and treating the disorder. As a result, needless and endless medical resources are recommended to assess and evaluate those affected. FD may present as a physical condition, a psychological disorder, or maybe both depending on the prominent symptoms. However, there is a strong correlation between having FD and psychiatric symptoms.

Main Text: FD occurs in early adulthood, with a mean age of onset of 25 years in both genders, although with differing demographic features. The lifetime prevalence of FD imposed on oneself in clinical settings is 1.0%, 0.1% in the overall population (ranging between 0.007% and 8.0%) and occurs more in female health care professionals. FD may make up 0.6%–3.0% of psychiatric referrals, and it accounts for 3-5% of doctor-patient contacts. In actuality, 1-2% of hospital admissions and an average of 6-8% of all psychiatric admissions have been underreported. The study aimed to highlight the signs and symptoms of FD identified in a psychiatry department of a multispecialty center and to increase the awareness of health practitioners. A critical review of the literature was done with an emphasis on psychological symptoms. PubMed, Mendeley, and Google Scholar were thoroughly searched and full-text publications of journals from 2010-2021 were included.

Conclusion: FD is a diagnostic puzzle that necessitates adequate, prompt medical attention as well as social support because of the potentially fatal consequence. A stronger patient-therapist relationship can strengthen the patient's conscious self-control to minimize the symptoms; therefore the healthcare provider has to be open-minded. For the diagnostic enigma to be removed and for ease of treatment, additional research, increasing awareness among medical professionals and the general public, accurate evaluation, diagnosis, and psychotherapy should be encouraged. These case studies will contribute to the knowledge base of FD and improve the quality of care.

Keywords: Factitious disorder, fictitious disorder, Munchausen's Syndrome, Malingering, psychiatric disorder, Simulated disorder. mental disorders

Background

In 1951, Richard Alan John Asher adopted Munchausen syndrome (MS) as a factitious disorder in the Lancet, a condition in which an individual intentionally produces symptoms to assume a sick role otherwise known as internal

or psychological incentive (1) and to gain medical attention.

Factitious disorder is an under-recognized and under-diagnosed mental disorder that challenges medical professionals in its diagnosis and management hence culminating

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in the wrongful use of medical resources to assess and evaluate those concerned (2).

There is a need to increase the awareness of medical personnel about this disorder for early identification, prompt culturally specific treatment, and research to detect the possible aetiological factors and prognosis to avoid unnecessary investigations and treatment. These will ultimately forestall complications, and burden of care and prevent further impact the disorder has on the national economy from expending taxpayers' or meager global health resources on unnecessary tests or procedures. Sufferers of FD may eventually be unproductive at work from absenteeism and may spend most of their time on the disability or hospital shopping while exerting pressure on the family finances accrued from the cost of care and frequent hospital visits, especially in nations where the burden of care is solely catered for by the citizens.

There have been several documented case reports and series on FD with varying presentations. FD can present as a physical disorder or psychological disorder or even both depending on the dominant symptoms. The prevalence of FD with psychological symptoms is high but is often under-recognized, underdiagnosed, or misdiagnosed. Due to the paucity of knowledge, more publications are encouraged to broaden our understanding of FD in practice and patient care (3). More so, to the best of our knowledge, there has been no record of FD with psychological symptoms in Nigeria. Rather the related publications were centered on children who presented with ocular symptoms, malingering, and factitious disorder by proxy (4, 5, 6). The dearth of information may emanate from practitioners who possibly desist from making the diagnosis of FD for fear of being wrong, and fear of litigation which is gradually becoming a fast-rising lucrative business among patients and their relatives globally. An accurate FD diagnosis will improve the care and quality of life of the patient, the attitude of the medical personnel, and the therapeutic relationship will improve.

Encouraging further research, spreading awareness among healthcare providers and the general populace, and proper evaluation, diagnosis, and psychotherapy will eliminate the diagnostic dilemma and make it easier to control and treat. These case reports will contribute to the knowledge of FD and the strategies to diagnose and treat the disorder (3).

Case Series

Case reports are an excellent source of information for factitious disorders over time.

FD can have serious emotional and financial ramifications for healthcare professionals as well as irreversible medical consequences for patients (7). Three instances are presented in this case series to show the psychological symptoms of factitious disorder.

Case 1

B.C is a 20-year-old undergraduate, who presented with a third episode of mental disorder with auditory and visual hallucinations, persecutory delusions, aggression, and irrational behavior. BC complained of recurrent "zoning out" and had a frequent acute exacerbation of symptoms and poor sleep while on admission. He reported problematic behavior at school, conflictual interpersonal relationships due to poor tolerance, acting-out behavior, anti-authority behaviors, trust issues, and significant lifetime and current substance abuse.

A multi-diagnosis of antisocial personality disorder, Mental and behavioral disorder due to multiple substance use- alcohol, cannabis, and nicotine (Alcohol dependence) and Paranoid Schizophrenia was made. Problems identified were Childhood sexual abuse, abandonment, neglect and molestation, multiple substance use, self-stimulating behaviors, and flashback. Other issues include childhood substance abuse, a persistent passive pattern of communication, low self-esteem, unhealthy social and coping skills (attention-seeking behavior, manipulative and compulsive lying), a lack of insight, blaming others for his difficulties, and impersonating healthcare professionals to extort money from his parents on one occasion.

BC completed Minnesota Multiphasic Personality Inventory (MMPI) in two sittings which produced an invalid protocol from a variable inconsistent response that was indicated by the Variable Response Inconsistency scale (VRIN). However, due to a lack of fixed, content-inconsistent responding, as indicated by the True Response Inconsistency scale (TRIN), the test was interpreted with caution.

During the assessment, BC reported more than the average number of infrequent severe emotional distress, greater than the average number of symptoms rarely described by individuals with genuine, severe psychopathology, and also indicated a very unusual combination of responses that is strongly associated with non-credible memory complaints which all showed the possibility of over-reporting.

He complained of isolation and subjective paternal abandonment which affected his

tolerance, and self-image, consequently, resulting in self-downing and criticalness, poor adaptation, unhealthy attention-seeking behavior, and constant need for validation from others, especially his father. He also complained about unhealthy comparisons with his siblings (resulting in sibling rivalry and hostility) and critical comments made by his parents in the past about his academic challenges, body build (endomorph), and mental and physical health issues. However, all these claims were rebutted during family therapy. It was established that his family loved and cared for him. After learning about the diseases, BC's father saw that BC frequently went to the hospital to complain about the symptoms of serious medical conditions. He also claimed that BC had attempted suicide on multiple occasions. During family therapy, BC snuck into the ward and pretended to the Matron that he had been offered admittance.

Analysis of the Draw A Person Test confirmed a range of personality traits of males and females with features suggesting virility conflict and detachment from close relations, deprivation of paternal affection, desire for interpersonal relationships, cry for help, self-centered and childish behavior, with a strong need for social approval from friends, low competence, and compulsive tendencies, feeling of being controlled, and gross dependency. He regretted his inability to retain his position in the family, his parents' criticalness, and being a member of that family. He was afraid of the future, and failure and had some pessimistic thoughts. He reported intense sadness, self-hatred, and suicidal ideation. He enjoyed solitary life (contrary to his desire for his father's love and attention), lonesome activities, and reading. According to his response, Rosenberg's self-esteem scale showed that he had low self-esteem and according to Beck Anxiety Inventory and Beck Depression Inventory he had severe anxiety and severe depression.

Several therapeutic interventions designed for this purpose include insight-oriented psychotherapy, bedtime ritual, and sleep hygiene, cognitive behavioral therapy, social skills/interpersonal therapy, motivational interview for substance use, self-esteem training, stress inoculation training, problem-solving skills training, family therapy, implosive therapy. Despite the intensive care, BC kept coming to the emergency room with different complaints of graded severity that warranted immediate intensive investigations and interventions, though the presentations were inconsistent with a formal diagnosis. During the implosive session, BC admitted that he had

been falsifying information and occasionally exaggerating his physical and psychiatric symptoms to get his parents' attention and sympathy from others, to help with his childhood neglect, and not to mind the missed lectures and quizzes.

A diagnosis of factitious disorder was made, and with continuous therapy, BC made significant improvement. He was more assertive in communication and social interaction. There was a significant reduction in unhealthy thoughts, and irrational reasoning, improved problem-solving skills, better insight and understanding of self, minimal self-acceptance and management, and a decrease in relapse rate and other unhealthy behaviors. His interpersonal relationships and communication with his father and roommates remarkably improved until he was lost to follow-up. However, after a while, the team was informed that BC had been admitted to another hospital.

Case 2

ST, a 16-year-old female undergraduate, presented with a 4-month history of frequent fainting spells. There was no history suggestive of phobias or other anxiety disorders. Basic cardiovascular and neurological investigations were essentially normal. She was then referred for psychiatric assessment and was diagnosed with conversion disorder with underlying clinical depression (suicidal ideation) and bronchial asthma. ST had a strained relationship with her mother, but she was pampered by her father. ST was offered admission, but she declined. Soon after she left the hospital, she was rushed to the ER due to an unpremeditated suicide attempt (ingested disinfectant). She claimed she had attempted to overdose on some prescribed medications before this and she complained of long-standing amenorrhoea. During admission, she confessed to a previous history of sexual assault on several occasions and substance use (alcohol, cannabis, and cigarettes). Investigations revealed deranged liver enzymes and, based on some other findings, other specialists (nephrologist, cardiologist, gastroenterologist, dietician, and gynecologist) were invited to review. Subsequently, ST came to the emergency room to complain of persistent suicidal thoughts, feelings of hopelessness, and anxiety symptoms on several occasions. She was always eager to be admitted and readily submitted herself for investigations and treatment. ST was observed to complain about symptoms the medical personnel asked about during the interview on the next visit to the emergency room. During a psychotherapy

session, she blurted out her plan to frustrate her mother's attempt to conceive and how she was enjoying her father's love and attention because of the illness. The diagnosis changed with each episode of Bipolar Affective Disorder, with varying episodes of depression, mania, and mixed, and the personality assessment revealed borderline personality. ST came frequently to the emergency room feigning psychosis and always complaining of suicidal ideation, which the team discovered was a manipulation of the medical personnel for admission or to gain sympathy and attention. The management team concluded that ST has a factitious disorder with underlying clinical depression, borderline personality disorder, and substance use disorder after much deliberation. The team, then, made a treatment plan for ST, which all the members strictly adhered to. She was placed on antidepressants, Folic Acid, mood stabilizers, and psychotherapy (Cognitive Behavioural Therapy and Dialectical Behavioural Therapy).

Case 3

MS, 18 years old, female, undergraduate, admitted via the Mental Health Clinic, presented with a history of low mood, weepy spells, suicidal thoughts, and restlessness all of the one-year duration. There was also a positive history of reduced concentration, reduced appetite, and energy, loss of interest in previously pleasurable activities, feeling of worthlessness, suicidal ideation, and auditory hallucination. There is a positive history of psychiatric illness (depression) in the eldest brother. It was gathered that MS had earlier failed her examination in school and was frantically scared of failing again. She was started on antidepressants and was placed on admission. Two weeks after discharge, she presented with symptoms of bipolar affective disorder and a current episode of severe depression with psychosis. This we confirmed was not iatrogenic because she stopped using antidepressants soon after her discharge and the manic symptoms were not observed while she was on the ward. She was managed and placed on tabs for antidepressants, mood stabilizers, and sedatives. She was admitted on several occasions, fluctuated between depressive episodes and bipolar affective disorder in her presentation, and had impulsively overdosed on her medications several times. She was managed by the cardiologist for high blood pressure and there was derangement in her liver enzymes from the overdose, which persisted despite the psychoeducation that was given on different occasions. While on the ward, MS imitated

symptoms of other patients or any differentials being ruled out during the ward round. She was always eager to know her diagnosis and, after doing some research, she complained about those symptoms to varying degrees but usually did not meet the diagnostic criteria. MS becomes angry when her request for voluntary admission was not honored but returns emergency room shortly after for compulsory admission due to a medication overdose. Our experience with BC raised our level of awareness and knowledge, making the identification of FD in ST and MS simpler and earlier.

Main Text

In the 18th century, Rudolph Erich Raspe, a German author, documented the character of Baron von Münchhausen, a military hero known to outrageously exaggerate his military adventures when relaying them (8). In the early days, some medical personnel was able to identify the disorder (9), but in 1951, Richard Asher adopted the Baron's name to describe a chronic factitious disorder (FD) that is characterized by a dramatic clinical presentation with recurrent hospital admissions in a novel extensive study (2). According to Asher, there were three forms of presentation of FD vis-à-vis acute abdominal (laparotamophilia migrans), hemorrhagic (haemorrhagia histrionica), and neurological (neuropathica diabolica) presentations (2, 10). Due to the mockery suffered by healthcare professionals during the treatment of persistent conflicting symptoms, FD has earned different pseudonyms like "hospital hopper syndrome", "hospital hobo syndrome", "thick chart syndrome", "black hole patients" or "peregrinating problem patients" from the caregivers (10).

Signs and Symptoms of Factitious Disorder

FD may present with physical or psychological symptoms or both, depending on the prevailing symptoms. These feigned psychological symptoms are often present in the absence of visible gains. Those who have genuine physical illness present with exaggerated symptoms, while others may come up with false subjective symptoms and/or false laboratory results just for medical management.

Persons with FD may come to the Emergency Department, specialist clinic, or General Outpatient Clinic. They sometimes claim false identities to unsuspecting medical personnel with complaints of unusual or dramatic symptoms like a fever of unknown origin, skin infections, anemia, asthma, Cushing's disease, pheochromocytoma, cancer, and

constitutional systemic symptoms of different organs like factitious haematuria, hemoptysis, torsion dystonia, feculent urine, self-mutilation, pulmonary manifestations, dermatitis artefacta, renal stones, hypoglycemia and diarrhea, seizures and paralysis (11, 12). Some present with self-induced alarming, exaggerated, aggravated, and refractory symptoms with worse prognosis (13), or multiple scars (12). These symptoms and signs are often inconsistent with the natural symptom profile of such disorder, they may not respond to appropriate treatment and may also require diagnostic and/or invasive procedures or treatments (12). The managing medical professionals may find it difficult to determine when the evidence is sufficient to make the diagnosis of FD, although elements including fictitious history, simulation, exaggeration, aggravation, and self-induction of the disease have been proposed to make the diagnosis easier (13).

FD was first recognized as a formal diagnostic category in DSM-III (14) but was classified into three major subtypes in DSM-IV-TR (15). In DSM-5, additional changes were made to include classification under somatic symptoms and related disorders; sub-classification as "factitious disorder imposed on self" and "factitious disorder imposed on another," factitious disorder by proxy was removed from the appendix, and the term "motivation to assume a sick role" was changed to "deceptive behavior that is present in the absence of external incentives" (14).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), an FD diagnosis is considered if the patient (16) fabricates physical or psychological signs or symptoms, inflicts injury or disease on purpose to deceive, pretends to be ill or injured, or has functional difficulties, continues to deceive without receiving any obvious benefit or reward, and when the patient's behavior is not better explained by other mental disorders, like delusions. The other characteristic features commonly presented are deliberate lying (*pseudologica fantastica*), frequent clinic/hospital shopping, making the same complaints during each visit; self-induced side-effects from excessive use of medications, recurrent abdominal pain, limb scars, rheumatologic and hematological disorders (17).

Epidemiology of Factitious Disorder

The onset of FD occurs in early adulthood for both men and women with a mean age of onset of 25 years but with different demographic profiles (18). The lifetime prevalence of

factitious disorder imposed on self in clinical settings is 1.0% and 0.1% in the general population (7, 19) ranging from 0.007% to 8.0% with higher prevalence in the female who were also health care professionals (18) FD may account for 0.6%–3.0% of psychiatric referrals (20, 21) and 3-5% of physician-patient encounters involve factitious disease (22). In practice, an average of 6–8% of total psychiatric admissions and 1–2% of hospital admissions has been documented with a possibility of underestimation (23).

Etiology of Factitious Disorder

The etiology of FD is a mystery but its association with psychosocial factors, neurocognitive impairment, and neuroimaging abnormalities are well documented. An abnormal MRI finding has also led to the formulation of a hypothesis that a correlation between congenital or acquired anatomical alteration of the central nervous system may give rise to the emergence of self-induced FD (23, 24). According to behaviorists, FD is a coping mechanism that is learned and reinforced in childhood from a poor sense of identity, distorted sexual adjustment, impaired frustration tolerance, and narcissism (13). Some may have subnormal or low intelligence quotient, while some may have associated thyroid abnormality (24, 25).

So far, little is known about the motivation for FD, but associated factors such as a desire for affection and care, an "adrenaline rush" from medical procedures, or satisfaction derived from deceiving healthcare professionals have been proposed (26). Other factors include unconscious motives, developmental or family factors, life stressors, psychodynamic mechanisms such as mastery, masochism (when there is a compulsion to self-inflict pain and seek self-punishment as atonement for various forbidden emotions and wishes, like sexual excitement or anger), a strong need for dependency (encountered in a socially acceptable medical setting), history of childhood abandonment and/or abuse, serious childhood and adolescent illnesses that require continuous treatments or repeated hospitalizations, loss of a loved one, personality disorders like borderline personality disorder (27), presence of mental disorders and bitterness against doctors (28, 29), the desire to feel superior to authority figures (satisfied by deceiving the therapist) and the satisfaction of exerting control over the authority (13).

The Prognosis of factitious Disorder

The prognosis is poor when FD co-occurs with other psychiatric disorders like depression,

anxiety, substance abuse, conversion symptoms, being in the medical profession, and malingering (30, 31). It is worth mentioning that FD and depression may share the same aetiological factors (32), like childhood trauma or neglect (33, 34), parental failures (35), marital difficulties (10), substance abuse (36), and stressful life events (37). On the other hand, FD may also be secondary to depression if there is low self-esteem or a compulsion to self-harm (10). Extensive research has also shown that personality disorders (particularly borderline and antisocial personality disorders) can have a significant impact on the prognosis of FD (9, 32, 38, 39).

There has been a conflicting report that FD with psychological symptoms may progress into some other major psychiatric disorders and feigning schizophrenia in a patient who has an underlying pronounced abnormal personality may be the prodroma of a genuine illness (28, 40). Pope et al refuted this claim in their 4–7-year follow-up study as none of their patients developed a true psychotic disorder (41). Contrary to this, Hay recorded that 4 out of the 5 identified cases in his study developed true schizophrenia after 3 months to 10 years of follow-up (28).

FD can be refractory to psychotherapy (42) but treating these underlying disorders and comorbidities, regular outpatient clinic attendance, and psychotherapy gives an excellent prognosis (3). The predictors of a favorable response to treatment include the presence of good psychosocial support and the ability to form a therapeutic alliance with a therapist characterized by the capacity to establish and maintain rapport, accept confrontation, and comply with treatment recommendations (43).

Discussion

It is assumed that many doctors will encounter at least one patient with FD in their practice. Among the myriads of publications, the work of Robertson and Hossain exceptionally described an unsuspecting case of a patient who underwent 42 surgical procedures during 850 admissions in 650 hospitals (44). From the many invasive procedures, FD patients are at risk of iatrogenic harm (45) from investigations and interventions though fatality report of FD is rare (38). Also, the recommendation of unwarranted investigations, treatments, and hospital admissions stifles the healthcare system from superfluous demands. For instance, the cost of care for an individual case of FD can exceed \$200,000 (46, 47) or maybe as high as \$1,000,000 (48), and, in all, the

treatment may cost a nation \$40 million or more annually (49).

Aside from the untoward effects of FD on sufferers, caring medical professionals are also vulnerable to the psychological impact. They may be resentful for being "tricked" and "exploited" of their valuable time and support (50) while others may feel guilty for agreeing to be coaxed into the emotional conflicts that often accompany the disorder (51).

In patient care, telemedicine is unique to modern-day medical consultation because it provides many benefits, such as making care more accessible and convenient. On the other hand, for FD patients, the internet may do more harm than good because it provides FD patients with a platform to gather information for their exploits, exposes them to various modes of presentation (52), helps with forging medical reports or referral letters (53) and allows the purchasing of prescription medications (10). Most patients with FD often resist psychiatric consultation, particularly those with physical symptoms. According to a report, only a third of the referred cases sought psychiatrist intervention (53), while the inverse is usually the case for those who have a predominance of psychological signs and symptoms, known as psychiatric Munchausen because they readily seek psychiatrist attention (12). It has been suggested that psychiatric Munchausen may be more common but may go unrecognized (54). In Spain, 8% of psychiatric admissions reportedly have factitious symptoms (23).

In the cases reported, psychiatric disorders like mood disorder, anxiety disorder, borderline personality disorder, antisocial personality disorder, suicide ideation/attempt, and substance use disorders coexisted with FD as previously reported (3). Therefore, in the management of FD, it is also essential to rule out other psychiatric differentials like malingering, monosymptomatic delusional disorders, illness anxiety behavior, psychotic disorders like schizophrenia, alexithymia, transient aphasia, and Broca's aphasia because they share some of the characteristic features of FD (3). Other similar diagnoses to consider during assessments are conversion disorder, somatization disorders, and true organic medical conditions (31).

Managing patients with FD require a high index of suspicion especially if the signs and symptoms are not consistent with items of phenomenology documented in the recognized manuals vis-à-vis Diagnostic and statistical manual (DSM) and international classification of Disease (ICD). Clinical perseverance, the proficiency to recognize common features, making a reliable diagnosis, objectively

addressing patients' concerns in a non-punitive manner, and helping patients to adopt coping styles that are face-saving are all needed for effective care (20). Failure of early identification and intervention may generate devastating complications such as suicide and disabilities which can be life-threatening. Taxpayers' resources or the family purse in nations like Nigeria where family members or patients are expected to pay from pocket for their health care can also be stretched further leading to frustration, family discordance, and an increase in the poverty level of the nation.

FD patients spend several years on disability, resulting in an enormous burden experienced due to the disease. Concerning our patients, more time was spent in the hospital than in school and more resources were expended on health care than necessary. Due to the illness, they missed several examinations, and trying to help them stabilize was frustrating to their parents and lecturers.

Just as experienced in the cases reported, medical personnel often face the dilemma of managing an individual with symptoms suggestive of FD. Making the diagnosis is often resisted due to fear of being wrong and being sued for negligence when intervention is delayed, especially in cases of genuine but exaggerated symptoms. Doctors are reluctant to diagnose malingering for similar reasons: for fear of assault, and more so, an error in diagnosing malingering may cause stigmatization and hindrance to much-needed patient care (55). Other vital contributory factors are the patient's lack of insight and disagreement with the diagnosis; hence, denying any kind of intervention. FD patients are often lost to care to pursue services in other facilities to benefit from receiving more unnecessary investigations and treatments (56).

Over time, it was agreed that early recognition of the disorder plays a key role in the successful management of FD (57). Prompt diagnosis will likely progress to early interventions thereby forestalling unnecessary harmful procedures. Confrontation therapy though beneficial has some disadvantages which outweigh the benefits. Therefore, some advised it should be avoided (58) or done in an inpatient setting for close monitoring while interventionists are counseled to observe their counter-transference reactions which can disrupt the therapeutic relationship (59).

To effectively manage our patients we adopted a mixture of confrontational and non-confrontational approaches and other psychological interventions. Unlike those who have physical symptoms and reluctantly agree

to therapy, providentially, people who have FD with psychological symptoms are willing to receive long-term psychotherapy or cognitive behavioral therapy, which incidentally is vital to the management (60). BC and ST were engaged in catharsis and hypnotherapy. All the patients were equipped with some life skills training to problem solve and to be assertive in expressing their feelings verbally instead of using sickness.

The suggested indicators of FD identified in our patients include perplexing, frequently changing unusual and inconsistent clinical signs and symptoms, unresolving symptoms despite appropriate treatment of the disorder being mimicked, increased expenditure on medical care, disabilities from the illness, display of symptoms or behaviors only when being observed, the frustration of medical personnel and using the symptoms to cry for help (13, 61).

Although the motivation for reporting the symptoms was not obvious to our patients initially, eventually they admitted to feigning the symptoms (8). With further psychotherapy, ST accepted she wanted to frustrate and dissuade the mother in her pursuit of conception, while for BC, the motivation was just to get sympathy and attention from his family members. Medical professionals are therefore encouraged to sharpen their clinical acumen to spot the disorder within the shortest possible time and proffer prompt intervention.

As part of the management, retaining a patient in care and ensuring proper documentation, which is accessible to other medical professionals in other centers, to fish out any patient that has absconded from treatment, cannot be over-emphasized. This will further prevent unnecessary investigations and treatment, putting an end to the continuous search for care. Keeping a "black list" in hospital registries or flagging an absconded patient can assist in identifying the absconder during assessment in other facilities. This strategy has been advocated by many, including Asher (2), to be efficacious and easy to implement, but comes with some fundamental ethical/legal issues such as breaching medical confidentiality, the risk of much-needed treatment refusal due to bigotry, and even logistic challenges. Despite these drawbacks, it is reportedly the most well-known preventive measure against factitious disorders' complications to date (8).

Conclusion

In conclusion, FD is a diagnostic dilemma that needs adequate, prompt medical and social attention because of the possible fatal outcome.

The management requires a high index of suspicion and open-mindedness on the part of the medical personnel. A strengthened patient-therapist alliance and frequent contact with carers, bearing in mind that iatrogenic effects exceed the harm resulting from self-induced or mimicked illness, have been shown to improve patients' conscious self-control to minimize the symptoms and to overcome treatment challenges and peregrination (3, 8, 62, 63, 64, 65, 66).

List of abbreviations

FD: Factitious Disorder
MS: Munchausen syndrome
DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders 4th Edition Text Revision
DSM-III: Diagnostic and Statistical Manual of Mental Disorders 3rd Edition
DSM-5: Diagnostic and Statistical Manual of Mental Disorders 5th Edition
ICD: International statistical classification of diseases and related health problems
ER: Emergency room
MMPI: Minnesota Multiphasic Personality Inventory
VRIN: Variable Response Inconsistency scale
TRIN: True Response Inconsistency scale

Declarations

Ethics approval, and Consent to Participate
Written informed consent for publication was obtained from the patient whose management is being reported.

Consent for publication

The author gave consent for the publication of the work under the creative commons Attribution-Non-Commercial 4.0 license.

Availability of data and materials

The data and materials associated with this review are publicly available.

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