DEALING WITH DECEPTION: FACTITIOUS DISORDER POST ANESTHESIA

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Abstract

Post-operative factitious disorder which is characterized by intentional voluntary behavioral patterns to produce physical and/or psychological symptoms that mimic a variety of diseases is extremely rare with few case reports in English literature. Such behavioral disorder has no apparent benefits for the individual concerned except for playing the sick role.

This is a case report of 28 year old male patient who dropped his Glasgow Coma Score (GCS) in Post Anesthesia Care Unit (PACU) 15-20 minutes after having recovered completely from general anesthesia. After ruling out the causes that delay recovery from anesthesia and cause deterioration in immediate postoperative period and also the patient's way of sudden arousal which lead to the feeling that he was falsifying his condition the diagnosis of factitious disorder was made.

In conclusion, one should suspect a factitious disorder when an otherwise young healthy patient shows deterioration of his/her sensorium, following complete recovery from an uneventful anesthesia for a relatively minor surgical procedure after ruling out any organic causes.

Keywords: Factitious Disorder, Munchausen syndrome.

Background

Factitious disorder (FD) refers to a psychiatric disease characterized by falsified symptoms and signs of illness deliberately produced by a patient for the purpose of playing a sick role. Such behavioral disorders have no apparent benefits for the individual concerned and does not have any external incentives (like economic or legal responsibility), which are apparent in malingering.[1] Usually many of these patients have medical background so they are familiar with the signs and symptoms of common diseases and routine tests performed for a particular presentation. A common finding in this disorder are the test results that are not consistent with the claimed illness.

More often this disease is used interchangeably with Munchausen's syndrome (MS): however the later condition is distinguished by its more extreme presentation and is usually refractory in nature.[2] The common presentations of FD varies from hypoglycemia, skin disorders, diarrhea and hypertension.[3,4,5] Unusual presentations of this disorder have also been reported in literature like delayed awakening from anesthesia, temporomandibular joint subluxation and hematemesis.[6,7,8] The diagnosis is usually made after all the organic causes have been ruled out.

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We present a case of young male patient who presented with FD soon after awakening from general anesthesia for a minor surgery. Informed consent for publication was obtained from ethics committee of our Institution.

Case

A 28-year-old male patient with medical background came to emergency room (ER) with acute abdomen. His examination revealed the features of acute appendicitis which was confirmed by CT scan with oral contrast. His past medical history was unremarkable except for a doubtful history of some anxiety disorder. He developed transient minor allergic reaction (itching and rash) to oral contrast during the CT scan which was treated successfully with an antihistamine. Patient was then transported to operating room and planned for appendectomy under general anesthesia after evaluation by the anesthesiologist.

Patient was connected to standard monitors and induction done with fentanyl 2µg/kg, propofol 2mg/kg and intubation facilitated with rocuronium 0.6mg/kg. The entire surgical procedure lasted for about 90 min and was uneventful. At the end of the procedure patient was extubated after reversing the residual effects of rocuronium with neostigmine 50µg/kg and glycopyrolate 0.4mg. He was responsive when brought to the post anesthesia care unit (PACU) for monitoring. Approximately 15-20min later his sensorium started to decrease and over the next couple of minutes he stopped responding to verbal commands, followed by sudden onset transient apnea with drop of oxygen saturation to 83%. This was followed by unresponsiveness to deep painful stimuli. Immediately, patient was attended to and evaluated by the rapid response team including, anesthesiologist, but patient started to breathe again without any intervention and his oxygen saturation increased to 100-% on oxygen but he did not regain consciousness. A gross neurologic examination performed by the attending anesthesiologist did not reveal any focal deficit, or altered tone, or abnormal posturing. The anesthesia medication cart was examined for evidence of unintentional administration of other medications, but no such error was detected. An arterial blood sample was drawn immediately and investigated for blood gases, glucose and electrolyte levels. All these investigations were within normal range. Stroke code was activated and the team on arrival examined the patient who was unconscious not responding even to deep painful stimuli, but with stable vitals. Patient was immediately taken for contrast CT scan of brain. When the patient was shifted to CT table, to the surprise of whole team he suddenly got up and said he was allergic to contrast media.

Still plain CT scan of brain was done which was normal and the patient shifted back to the ward. Later on neurological and psychiatric evaluation was done for this patient. Although he admitted being under stress in the family but he did not accept feeling depressed with it. Patient was discharged home on third postoperative day. He is under follow up of psychiatrists in our hospital. The overall conclusion based on the patient's presentation and multispecialty consultations including psychiatry were all highly suggestive of FD.

Discussion

Immediate post anesthesia deterioration in the PACU has several causes ranging from minor to several life-threatening diseases. Alterations in physiological parameters or 'vital signs' commonly precede serious adverse events.[9] Thus the anesthesiologist should possess a sharp acumen to promptly identify these changes, diagnose the underlying pathology, and if required, to treat (or arrange treatment for) any such pathology. Several etiologic factors must be considered which may delay recovery from anesthesia. These include the residual effects of anesthetic agents causing impaired oxygenation and respiratory acidosis, deranged plasma electrolyte and glucose levels, hypothermia, cerebral insults (for example, cerebral vascular thrombosis/embolism, rupture of aneurysms) and seizures.[10] However, etiologies which result in decrease in sensorium subsequent to complete recovery from anesthesia primarily include hypoglycemia, hyponatremia, sudden onset cerebral pathology and seizures.

In our patient the timeline and acuity of the patient's presentation did not align with these causes. It was only when patient got alarmed of possible injury

by the contrast media and immediately became alert voicing his apprehension to contrast reaction, we realized that he was falsifying his condition and all his symptoms were factitious.

History of FD dates back from 1951 when Richard Asher described case reports of patients who used to migrate from one hospital to another in seeking medical attention through feigned symptoms.[11] Asher named this condition Munchausen syndrome (MS), after Baron von Munchausen, a retired German cavalry officer who had tales of his life stolen in a booklet in 1785. Since then numerous reports of patients producing or falsifying an illness have been reported in literature. However, the term MS is best reserved for those patients who have chronic extreme variant of FD. In practice many clinicians still use the term MS interchangeably with FD and describe it as persons who intentionally feign or produce illness, however MS is not included as a discrete mental disorder either in The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*) or in World Health Organization's International Statistical Classification of Diseases, 10th revision (ICD-10).[1,12] According to both systems the official diagnosis for such cases is factitious disorder. Still some experts have identified a subset of patients with FD for whom they reserve this term of Munchausen's syndrome. These are those patients whose illness behavior is particularly chronic and severe, patient moves from hospital to hospital and town to town to find new audience, and make false claims regarding educational credentials, accomplishments, relations to famous persons and so forth. Patients with MS have no social contact with anyone other than health care professional. In 1977, another term MS by proxy was described in which an individual artificially produces illness in another person like a mother producing an illness in her young child.

As outlined by American Psychiatric Association's Diagnostic and statistical Manual of mental disorders (DSM-5) FD is divided into two types:[1]

1) Factitious disorder imposed on self

2) Factitious disorder imposed on another (proxy)

The specific DSM-5 criteria for diagnosis of FD imposed on self are as follows:[1]

1) Intentional production or feigning of physical or psychological significant signs and symptoms.

2) The motivation for the behavior is to assume the sick role.

3) External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical wellbeing as in malingering) are absent.

The conversion disorder is also frequently confused with factitious disorder. This disorder is characterized by occurrence of specific signs and symptoms without any organic cause but in those cases patient is not intentionally feigning such symptoms but actually experiencing them.[1]

Factitious disorders generate unnecessary anxiety to the treating physicians with wastage of their time and health resources. Various presentations of FD and conversion disorder after uneventful anesthesia are reported in literature.[13,14] A multipronged strategy is needed to diagnose, such cases. Collateral information can also provide significant information that can help in the diagnosis.

The pathophysiology of this disorder has not been determined. However, in one case report, single photon emission computed tomography (SPECT) found hyper perfusion of right hemi-thalamus.[15] Whether the observation of SPECT is replicable in larger samples need to be ascertained.

When the diagnosis of FD is made psychiatrist can assist in clarifying the diagnosis, making aware the medical team regarding the illness and ways to confront these kinds of patients, as confrontation should be done in supportive manner. A non-confrontational approach is basically recommended management strategy.[16]

Conclusion

In conclusion, FD is a frustrating and a challenging psychiatric disorder. It can present to physicians in any field be it surgery, emergency room, anesthesia etc. Identification of such cases require high index of suspicion and collaboration with psychiatry that may prevent unnecessary interventions and poor outcomes. Anesthesiologist should suspect FD when an otherwise young healthy patient shows deterioration of

his/her sensorium, following complete recovery from an uneventful anesthesia for a relatively minor surgical procedure after ruling out any organic causes.

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