

# Fabricated facial rash – an unusual presentation of factitious disorder

S. Rice,\*<sup>1</sup> K. O'Brien,<sup>1</sup> M. Chew<sup>2</sup> and E. Qudairat<sup>1</sup>

## Key points

Suggests clinicians may occasionally be misled by those who present with factitious signs or symptoms.

Highlights that prompt detection of such cases ensures that patients do not receive unnecessary interventions that may ultimately be harmful.

Suggests comprehensive history taking and assessment, along with multidisciplinary teamwork, is crucial in identifying these patients and managing them in a sensitive and appropriate manner.

Patients with factitious disorder typically present with signs or symptoms suggesting a medical problem, but which transpire to be self-induced or fabricated. Repeated investigations and treatments are often carried out to no avail before this possibility is considered. In this case, a 51-year-old female presented to the oral and maxillofacial surgery unit with toothache and a facial rash. Following admission to hospital a range of investigations were performed, and a tooth was extracted. Judicious attention by nursing staff led to the discovery that the patient had been applying make-up to mimic a skin rash. This concern was raised with the patient and she admitted falsifying the rash. Although this patient may have been experiencing pain, by applying make-up in this manner she sought to exaggerate the severity of her condition and as a result underwent potentially unnecessary procedures. This case provides a reminder that the possibility of factitious disorder should be considered in cases where patients present with symptoms or signs which appear fabricated or self-inflicted, defy anatomical or physiological principles, or do not correlate with the history. Thorough history taking is essential, and access to electronic care records may be informative. Psychiatric follow-up is recommended, but not all patients are willing to engage with this process.

## Introduction and background

The condition now known as 'factitious disorder' was first described by the physician Richard Asher in 1951. He labelled it 'Munchausen's syndrome' after the eighteenth century nobleman Baron von Munchausen who was alleged to have travelled widely, telling dramatic and untruthful tales.<sup>1</sup> The term was used to describe the condition where patients present to medical professionals with falsified signs and/or symptoms of disease, often backed up by detailed histories. Other terms historically used include 'hospital-hopper syndrome' and 'peregrinating patient syndrome'.<sup>2</sup> Some authorities continue to use the term

Munchausen's syndrome when referring to severe cases characterised by dramatic presentation and habitual deception.<sup>3,4</sup> However, in line with contemporary diagnostic criteria including the WHO *International Classification of Diseases*, tenth revision (ICD-10)<sup>5</sup> and the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5),<sup>6</sup> the term 'factitious disorder' is preferred and will be used in this article.

Factitious disorder is described in ICD-10 as the intentional production or feigning of symptoms or disabilities, either physical or psychological. It differs from other similar psychiatric conditions in that the main aim for the patient is to assume the 'sick role'. In drug-seeking behaviour or malingering there is a clear external motivation for the patient's actions (such as access to medications, financial gain or work avoidance), whereas in factitious disorder, there is no obvious reward for the behaviour. It differs from somatoform disorders (a group of psychiatric conditions which manifest with unexplained physical

symptoms) by the intent of the patient to deceive others. However, in reality the boundaries between these conditions and factitious disorder can be unclear, and there may be a degree of overlap in some patients.<sup>7</sup>

The prevalence of factitious disorder is estimated to be 0.5–2%,<sup>7,8</sup> but it is likely to be under-detected due to the secretive nature of patients with the condition, and the fact that they often abscond if confronted. The condition is particularly prevalent in single women in their third or fourth decades of life, and up to half of those affected work in healthcare-related occupations.<sup>7</sup> There is a strong correlation with chronic physical and psychiatric conditions, as well as with adverse psychosocial factors during childhood or adolescence such as bereavement, abandonment, institutionalisation or abuse. It has been suggested that by adopting the 'sick role', susceptible persons can form new relationships and allow their unmet emotional needs to be addressed.<sup>7,9</sup> This theory is supported by a recent study, which found that a desire to receive affection was the reason

<sup>1</sup>Department of Oral & Maxillofacial Surgery, Ulster Hospital, Dundonald, Northern Ireland; <sup>2</sup>Department of Old-age Psychiatry, Knockbracken Healthcare Park, Belfast, Northern Ireland.

\*Correspondence to: Steven Rice  
Email: srice04@qub.ac.uk

Refereed Paper. Accepted 7 September 2018  
DOI: 10.1038/sj.bdj.2018.1036

**Table 1 Constructive confrontation - preparation and process for non-psychiatrists (adapted from Bass and Halligan, 2014)<sup>7</sup>**

Step 1	Collect firm evidence of fabrication
Step 2	Discuss with psychiatrist (or member of hospital legal team if no psychiatrist available)
Step 3	Arrange meeting to collate the facts, devise strategy, and discuss with primary care doctor
Step 4	Confrontation with patient should be non-judgemental and non-punitive, and should include proposal of ongoing support and follow-up
Step 5	Discuss the outcome of the confrontation with the primary care doctor
Step 6	If the patient is a healthcare worker the doctor should discuss with a member of their defence organisation/hospital legal team, as it may have implications for their employment
Step 7	Document a full record of the meeting and its outcome in the patient record

most frequently cited by patients with factitious disorders for their behaviour.<sup>10</sup> However, it is thought that the patient's personality also plays a role in the aetiology, as the condition is more common in those with dissocial, narcissistic or emotionally unstable personality disorder.

Patients with factitious disorder may present with physical and/or psychiatric signs or symptoms. A number of methods may be used including:<sup>7</sup>

- Exaggerating or fabricating signs or symptoms
- Exacerbating pre-existing conditions by not adhering to medical advice (for example, precipitating seizures by not taking medications)
- Presenting benign physical findings as pathological (for example, a patient with pre-existing electrocardiogram abnormalities complaining of chest pain)
- Interfering with medical investigations or tampering with laboratory specimens
- Falsifying medical records or using an alias.

Patients frequently present late at night or at weekends.<sup>11</sup> The usual pattern is one of multiple discrete episodes, often with the patient presenting to different hospitals each time. However, one-off and chronic, unremitting episodes have also been reported.<sup>7,12</sup> Factitious disorder may coexist with organic diseases, including their presenting complaint. In such cases, the patient aims to convince the clinician that their condition is more severe than it actually is by exaggerating their signs or symptoms.

It is difficult to acquire definitive evidence of a factitious disorder, and it is important not to overlook an organic condition which may require urgent treatment. However, it may be suspected in cases where one or more of the following features are present:<sup>7,13</sup>

- The patient is observed during the act of inducing illness, or evidence of this is detected (for example, unexpected medications or related paraphernalia such as syringes are found in the patient's possession)
- Evidence that the patient has tampered with records or specimens
- Inconsistencies in the patient's history
- Symptoms not in keeping with examination findings or investigations
- An atypical pattern of illness or an unusual response to treatment
- Unexpected worsening of symptoms before planned discharge
- Unusually frequent attendance at healthcare providers or unexplained use of multiple facilities
- Eager acceptance of invasive and risky investigations or treatments
- Few visitors during hospital stay, or confrontation of the patient by family members who suspect factitious illness
- Unwillingness for psychiatric involvement
- Refusal to allow access to previous medical notes.

In the UK the most commonly used diagnostic criteria is ICD-10, which characterises factitious disorder as a condition where 'the patient feigns symptoms repeatedly for no obvious reason and may even inflict self-harm in order to produce symptoms or signs. The motivation is obscure and presumably internal with the aim of adopting the sick role. The disorder is often combined with marked disorders of personality and relationships'.<sup>5</sup> However, there must not be an alternative physical or mental disorder which could explain the symptoms, therefore it is essential to exclude other underlying conditions before making this diagnosis. The term 'factitious

disorder' should be used when making entries in a patient record.

When broaching the suspicion of a factitious disorder with patients, a sensitive and non-punitive approach is recommended. Ideally, two members of staff should be present, and emphasis should be placed on recognising that the patient needs help and providing reassurance that this will be provided. Attempts should be made to minimise patient humiliation and a 'confession' should not be forced.<sup>7</sup> It is important to discuss the entire range of differential diagnoses and assure the patient that their concerns are being taken seriously, however any evidence that the condition is factitious in nature should be presented objectively and openly discussed with the patient. Patients may be concerned that being labelled with a factitious disorder may mean that they will not be believed by medical professionals in the future, and these fears should be alleviated. A psychiatric opinion should be obtained, and the patient's general practitioner and all clinicians involved in their care should be informed, preferably with the consent of the patient. High-risk patients should be closely monitored to reduce the likelihood of self-harming behaviours, and ideally one doctor should coordinate and take primary responsibility for the patient's care, with the input of relevant specialties as required.<sup>14</sup>

Bass and Halligan have suggested a management strategy for non-psychiatrists when faced with a patient whom they suspect of having a factitious disorder.<sup>7</sup> This has been described as 'constructive confrontation', and is detailed in Table 1. It is not a substitute for specialist psychiatric evaluation, however, it provides guidance for immediate management if clinicians suspect a factitious presentation. Where feasible, it is good practice to discuss these suspicions with experienced colleagues before raising them with the patient in an attempt to exclude other causes that the clinician may not have considered. Raising the suspicion of factitious disorder with a patient will inevitably change the dynamic of their relationship with the clinician, and should not be undertaken without careful consideration.<sup>15</sup>

Definitive management of such patients is challenging as they are frequently reluctant to engage in treatment and often abscond upon discovery. In one study where 75% of patients with suspected factitious presentations were confronted, only one in six admitted to fabricating their illness and only 12% agreed to psychiatric follow-up.<sup>13</sup> Treatment is usually

only possible if the patient admits they have a problem and accepts help. Cognitive behavioural therapy (CBT), psychotherapy and antidepressants have been tried. There is a lack of evidence to support any of these strategies, although in some cases patients appear to have responded well to psychotherapy or CBT.<sup>14</sup> There has been little research into the long-term success rate of treatment, however, complete recovery is rare. It is thought that the condition is more refractory in patients with personality disorders and in those who are diagnosed late in their clinical course.<sup>7</sup>

It is unusual for patients with factitious disorder to present with dental or oral complaints, but over the years a number of cases have been reported. These include reported severe and intractable facial pain, factitious mucosal trauma,<sup>3</sup> and even submandibular pain leading to removal of a healthy submandibular gland.<sup>2</sup> In this report we describe a case where a patient presented with dental pain and a fabricated facial rash. By highlighting this case we hope to increase awareness of factitious disorders involving the face and oral cavity, and the importance of comprehensive history-taking, a sensitive and compassionate approach, and multidisciplinary teamwork in detecting and managing such cases.



**Fig. 1** The patient's facial appearance prior to discharge. The make-up from the central part of her left cheek has been removed using an alcohol wipe

## Case report

A 51-year-old woman presented to the oral and maxillofacial surgery (OMFS) unit via the emergency department (ED) with left-sided dental pain and a skin rash, which she stated had developed over the previous few days. She had a past medical history of hypertension, asthma, polycystic kidney disease and myalgic encephalopathy. She had been admitted to hospital under the care of OMFS one year previously due to severe pain and facial erythema following extraction of 34. This settled over a period of one week with local measures and antibiotic therapy.

The patient was afebrile but had a well-defined erythematous rash extending from the left labial commissure to the lower border of the mandible. Tooth 35 was tender to percussion and contained a large amalgam restoration. The dentition was heavily restored but there were no other acute findings of note, and radiographically there was no evidence of periradicular pathology. The patient was advised that she most likely had periapical periodontitis of 35 and should attend her dentist for further treatment. She was discharged on antibiotics and analgesics, and attended the out-of-hours dental emergency clinic that evening for pulp extirpation.

The patient returned to the ED in the early hours of the following morning complaining of severe pain. She had also developed a florid rash that extended from the left periorbital region to the supraclavicular area. There was no significant swelling apart from mild cervical lymphadenopathy. She was admitted to hospital (despite some initial reluctance), given a long-acting local anaesthetic injection and commenced on intravenous antibiotics. At this point, the extent of the rash was marked out on the patient's skin. Blood tests showed an unremarkable white cell count of  $6.4 \times 10^9/l$  and a C-reactive protein level of 5 mg/l. Over the course of the next 24 hours the patient requested further local anaesthetic injections on two occasions. Inferior alveolar blocks were administered, with apparently good effect.

The following day, after a discussion regarding treatment options, the patient had an uncomplicated extraction of 35 under local anaesthesia. On her return to the ward she fainted, reportedly due to pain. She was reviewed by the acute pain team and started on regular opioid analgesics. The next morning the patient appeared much better, with partial resolution of the skin rash.

Later that day the nursing staff contacted the OMFS team as they had noticed pink staining around the neckline of the patient's clothing. She had also refused to allow the skin markings to be removed. They suspected that the patient had been applying make-up to mimic a skin rash, and this concern was raised with the OMFS consultants. Following liaison with the on-call psychiatrist the patient was taken to a quiet area, accompanied by a senior nurse and two consultants, and questioned regarding these concerns. Initially she denied them, but subsequently admitted that she had applied make-up to her face and neck before and during her hospital admission, with the intent of convincing the medical staff that she had a rash (Fig. 1). She apologised for her actions, revealing that she suffered from depression and had been dealing with a lot of family-related stress at the time of her presentation. The patient was offered the opportunity to see a psychiatrist the same day, however, she refused and was subsequently discharged from the ward. A review appointment within the OMFS department was arranged but the patient failed to attend. She was also referred for outpatient psychiatric follow-up, however, we were unable to determine if she engaged with this service.

## Discussion

In relation to the oro-facial region, a small number of cases of factitious disorders have been reported in the literature. Most of these involve self-inflicted mucosal or cutaneous trauma, and mimicking a skin rash in this manner is thought to be unusual. In this case the patient had presented twice to the OMFS department over a ten-month period, and on both occasions she presented out-of-hours and was initially assessed by a junior staff member. This may have been her intention, as she might have believed it would be more straightforward to convince a less experienced clinician that her condition warranted hospital admission. As factitious disorders may be co-morbid with organic diseases, it is possible that she was experiencing dental pain when she was initially assessed. However, it is clear that she exaggerated the extent of her rash when she returned to the hospital.

This patient underwent numerous uncomfortable injections, received a potentially unnecessary dental extraction, and spent several days in hospital. It is difficult to know what her underlying motivation was but

possibilities include seeking respite from a stressful home situation (which she alluded to when confronted), or the desire to receive attention by assuming the sick role. Although the patient did receive opioids, her active approach to requesting uncomfortable procedures such as local anaesthetic injections would suggest that drug-seeking was not her main motivation. As it is possible for malingering behaviour and factitious disorder to coexist, she may have sought both respite and attention through her behaviour.<sup>7</sup>

In this particular case, electronic clinical records did not demonstrate any definite previous factitious presentations but they did enable OMFS staff to find details of the patient's similar presentation a year earlier. In future, if this patient presents to her general practitioner or to hospital with unusual signs or symptoms, the details recorded during this episode may be useful for the clinicians involved. In this region of the UK, only mental health staff directly involved in a patient's care have access to their psychiatry electronic records. This makes it difficult for other clinicians to find out information about a patient's psychiatric history if they are not forthcoming with it. However, there are reports of other cases where the use of electronic medical records facilitated the detection of patients with factitious disorders, even when aliases were used. As a result, these patients were spared unnecessary interventions and were referred to psychiatry for onward management.<sup>16</sup>

On reflection, the OMFS on-call staff believed that this patient had an odontogenic infection on her initial presentation, and this was managed accordingly. Factitious disorder presenting with a dental complaint is unusual and none of the staff involved had previously encountered a case. However, in retrospect there were several atypical features of this patient's presentation – particularly the florid, extensive rash in the absence of significant swelling or raised inflammatory markers. She also displayed a number of the aforementioned features that can suggest that a presentation may be factitious in nature. Therefore, this case provided a reminder to consider the possibility of a factitious disorder, particularly in cases where the clinical findings are inconsistent with the history or suspected diagnosis.

The case also demonstrated the importance of taking a comprehensive history, focusing not just on a patient's medical background but also on psychological and social factors which may have an impact on their diagnosis and management. As discussed previously, patients who present with factitious disorder often have chronic physical or psychological co-morbidities and it is essential to take time to explore these in a thorough and compassionate manner. If this had been done more thoroughly at the time of presentation, this patient's underlying psychosocial issues may have been detected sooner and she could potentially have been managed more appropriately.

In view of these learning points, it was felt that this case was worth sharing – both to highlight the possibility of factitious disorder as a diagnosis and to demonstrate the importance of comprehensive and sensitive history-taking, particularly in patients who present in an unusual manner or for whom underlying psychosocial factors are likely to play a significant role.

It is appreciated that managing a patient with a suspected factitious disorder in primary dental care will be particularly challenging as it will not be possible to access electronic health records, a psychiatric opinion, a hospital legal team or colleagues experienced in managing such issues. It may also be complicated by concerns that the dentist-patient relationship, often built up over many years, will be compromised. However, it is important to address the issue to ensure the patient does not receive unnecessary treatment and is referred for appropriate follow up. It is hoped that the principles described above will be useful to any clinician who finds themselves in a similar situation. It is particularly important for the dentist to raise concerns with the patient in a sensitive and non-judgemental manner, liaise with their defence organisation and the patient's general practitioner, and ensure the encounter is well documented using appropriate terminology.

## Conclusion

Factitious disorders may occasionally present with oro-facial signs or symptoms. In cases such as the one described, it is often only after patients have undergone a number of investigations and procedures with no clear benefit

that this possibility is considered. Multi-disciplinary involvement, consideration of underlying psychosocial issues and a sensitive, non-judgemental approach are crucial when managing such cases.

Psychiatric follow-up is recommended, however, many patients do not engage with treatment and the rate of complete recovery is thought to be low. A large proportion of patients go on to re-present with further factitious episodes. The use of electronic care records has been shown to be useful in putting together the pieces of the puzzle and facilitating the detection of factitious disorders, particularly if the patient has previously presented to other hospitals or specialties with spurious signs or symptoms.

### Declaration of interests

None of the authors of this paper have any conflict of interests to declare.

1. Asher R. Munchausen's Syndrome. *Lancet* 1952; **1**: 339–341.
2. Scully C, Eveson J W, Porter S R. Munchausen's Syndrome: oral presentations. *Br Dent J* 1995; **178**: 65–67.
3. Heasman P A, MacLeod I, Smith D G. Factitious Gingival Ulceration: A presenting sign of Munchausen's Syndrome? *J Periodontol* 1994; **65**: 442–447.
4. Huffman J C, Stern T A. The diagnosis and treatment of Munchausen's syndrome. *Gen Hosp Psychiatry* 2003; **25**: 358–363.
5. WHO. International Statistical Classification of Diseases and Related Health Problems. 10th Revision. 2016. Available at <http://apps.who.int/classifications/icd10/browse/2016/en> (accessed August 2018).
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth edition (DSM5), Arlington, VA: American Psychiatric Association, 2013.
7. Bass C, Halligan P. Factitious disorders and malingering: challenges for clinical assessment and management. *Lancet* 2014; **383**: 1422–1432.
8. Fliege H, Grimm A, Eckhardt-Henn A, Gieler U, Martin K, Klapp B F. Frequency of ICD10 factitious disorder: survey of senior hospital consultants and physicians in private practice. *Psychosomatics* 2007; **48**: 60–64.
9. Kozłowska K. Abnormal illness behaviours: a developmental perspective. *Lancet* 2014; **383**: 1368–1369.
10. Lawlor A, Kirakowski J. When the lie is the truth: grounded theory analysis of an online support group for factitious disorder. *Psychiatry Res* 2014; **218**: 209–218.
11. Wright P, Stern J, Phelan M. *Core Psychiatry*. First edition. London: WB Saunders, 2000.
12. Goldstein A B. Identification and classification of factitious disorders: an analysis of cases reported during a ten year period. *Int J Psychiatry Med* 1998; **28**: 221–241.
13. Krahn L E, Li H, O'Connor M K. Patients who strive to be ill: factitious disorder with physical symptoms. *Am J Psychiatry* 2003; **160**: 1163–1168.
14. Eastwood S, Bisson J I. Management of factitious disorders: a systematic review. *Psychother Psychosom* 2008; **77**: 209–218.
15. Steel R M. Factitious disorder (Munchausen's Syndrome). *J R Coll Physicians Edinb* 2009; **39**: 343–347.
16. Van Dinter T G Jr, Welch B J. Diagnosis of Munchausen's syndrome by an electronic health record search. *Am J Med* 2009; **122**: e3.