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Case report

Factitious disorders in the hand–Main diagnostic traps highlighted with 3 cases

Les troubles factices de la main. Pièges diagnostiques à propos de 3 observations

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ABSTRACT

Every doctor can be confronted, during his career, with patients presenting symptoms they created themselves. Because it is easily accessible, the hand is a favored target organ for these self-inflicted injuries. The diagnosis of factitious disorder of the hand is very difficult, rarely suggested and widely under-estimated. The real issue is detecting it early on to develop a cohesive diagnostic and therapeutic approach. The three clinical cases reported in this article illustrate the difficulty of caring for this pathology at all stages, from diagnosis to treatment. These disorders must be distinguished from malingering. A psychiatrist must be part of the treatment team. The prognosis of factitious disorders is poor. It is vital to maintain contact with the patient once the diagnosis is established. The risk is that the patient consults with other professionals, restarting a new cycle. The featured clinical cases were chosen to remind surgeons that factitious disorders of the hand are a recognized psychiatric disease. It must be evoked in the context of an unusual injury with a vague history. Everything possible must be done to confirm the diagnosis and avoid surgery.

Mots clés :
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RÉSUMÉ

Tout médecin peut être confronté, au cours de son exercice, à des patients présentant des symptômes qu'ils ont eux-mêmes créés. La main, facilement accessible, est un organe cible privilégié pour ces pathologies auto-induites. Le diagnostic de trouble factice de la main est très difficile à poser, il est rarement évoqué et largement sous-évalué. L'enjeu de cette pathologie est pourtant de la détecter précocement pour élaborer une tactique diagnostique et une thérapeutique cohérente. Les trois cas cliniques rapportés illustrent la difficulté de prise en charge de cette pathologie à toutes les étapes, du diagnostic au traitement. Ces pathologies sont à distinguer des simulations et la prise en charge doit être psychiatrique. Le pronostic des troubles factices est sombre et l'enjeu est de ne pas perdre de vue le patient une fois le diagnostic établi. En effet, le risque est que les malades consultent auprès d'autres professionnels, recommençant le cycle d'une nouvelle histoire. Les cas cliniques présentés ici rappellent aux chirurgiens que les troubles factices de la main sont une pathologie psychiatrique reconnue. Dans un contexte de lésion inhabituelle avec une anamnèse floue, il doit être évoqué. Tout doit alors être mis en œuvre pour affirmer le diagnostic et la chirurgie doit être évitée.

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1. Introduction

During their career, every physician will likely encounter patients with symptoms they invented themselves. According to the 10th revision of the International Classification of Diseases (ICD-10), a factitious disorder or pathomimicry is characterized by physical or psychological symptoms that are intentionally produced to assume the "sick" role. There is no external incentive for the behavior, such as economic gain or avoiding legal responsibility, and the person is unaware of any self-motivating factors [1–3].

This disorder can be encountered in every medical specialty [3]: anemia due to induced bleeding (such as Lasthénie de Ferjol syndrome), dermatological pathomimicry (ulcers, abscess by subcutaneous injection of septic liquids, burns by rubbing, blisters from local burns), hypoglycemia due to occult intake of insulin, etc. However, the hand is the preferred target for these self-inflicted injuries [4].

The diagnosis of a factitious disorder is rarely made and its frequency is greatly under-estimated [5]. While it is impossible to reliably establish the prevalence of this disorder, because of its nature and the resulting diagnostic difficulty, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) states that about 1% of hospitalized patients have clinical features consistent with these criteria:

- intentional production or feigning of physical or psychological signs or symptoms;
- the motivation for the behavior is to assume the sick role;
- external incentives for the behavior are absent.

The challenge is detecting this disorder early on to come up with a coherent diagnostic and therapeutic approach. The diagnostic procedure must be rigorous, with the goal of eliminating other possible diagnoses, as it is a diagnosis of exclusion. It is important to know how it differs from malingering as the person is not motivated by personal gain (e.g. money or avoiding work); on the contrary, the diagnosis of a factitious disorder is based on the absence of an objective reward.

The risk is that additional supplementary examinations, and sometimes even surgical procedures, are carried out that can lead to potentially serious medical complications [6]. The three cases reported here were chosen because they fall within the three broad types of factitious disorders of the hand while highlighting the challenges associated with managing this disorder at every stage—diagnosis to treatment.

2. Case reports

The first patient is a 24-year-old woman who presented with subchronic symptoms suggestive of compartment syndrome in her left hand. She indicated that a subacute injury had occurred 10 days prior. While the cause was obscure, clinical examination found a true compartment syndrome of the hand (Fig. 1A and B) requiring emergency surgical care with decompressive fasciotomy (Fig. 1C and D). The emergency context and the incomplete medical history delayed the diagnosis, even though the disease's story had some inconsistencies: the patient explained the symptoms resulted from a fall but could not provide exact details of the incident. In the end, self-mutilation acts observed by the nursing team during the patient's hospital stay allowed us to make the diagnosis.

The second patient was a 40-year-old female with a chronic wound on the dorsal side of the metacarpophalangeal joint of the 3rd ray of her right hand (Fig. 2A). She said that a mass appeared spontaneously 1 year before that required two synovectomy procedures at another hospital, but no wound healing was ever achieved. While the diagnosis was suspected at the first visit, it could not be retained immediately because it is a diagnosis of exclusion. The patient was operated again: synovectomy with diagnostic and therapeutic aims. This diagnosis took longer and was more difficult to make. It was made based on the unusual and protracted postoperative course with lack of wound healing and progressive deterioration of the local skin condition over time (Fig. 2B), despite appropriate local skin care and negative microbiological samples. Multidisciplinary care with a stay in the psychiatry ward resulted in complete healing.

The third patient was a 9-year-old girl from a socially disadvantaged environment who was left to her own devices. Her mother was receiving medical care for vague clinical disorders and had initiated legal claims against the medical profession. Following a benign injury to the little finger of her left hand, she presented with increasingly disabling clinodactyly that was non-reducible and painful. The diagnosis was immediately suspected given the clinical examination, normal radiographs and context. External treatment was implemented to build the relationship with, and trust in, the care-giving team. This provided us with sufficient time to organize multidisciplinary care in a short-stay pediatric hospital. Complete reduction of the clinodactyly under general anesthesia confirmed the diagnosis. Immobilization with a brace along with overall care, follow-up with a child psychologist, help at home and extracurricular support by a teacher lead to complete healing.

3. Discussion

Factitious disorders are a known psychological problem that are difficult to diagnose [2,5] and have a poor prognosis. Thus, it is essential to make the diagnosis quickly and adapt the treatment to the patient. Grunert et al. [1] defined three types of factitious disorders of the hand in 1991:

- self-mutilation and wound manipulation: This type corresponds to dermatological pathomimicry, which is the most common factitious disorders. It has two sub-types:
  - in the first sub-type, the lesion is created by excessive scratching, cutting, burning, pin pricking, or by injecting or introducing various materials. There are numerous published clinical cases detailing the injection of saliva, fecal matter, cigarette ash, urine, bacterial cultures, milk, dirt, deodorant, air, vegetable matter, paraffin, etc.,
  - in the second sub-type, the patients are labeled as "passive mutilators" [7]: they convince the surgeon to create a lesion through a surgical procedure;
- factitious edema: This also has two sub-types based on the mechanism used to provoke the edema, whether traumatic or obstructive:
  - the best known clinical presentation of factitious edema due to trauma is Secrétan's syndrome, which corresponds to hard swelling on the dorsal side of the hand associated with peritendinous fibrosis,
  - obstructive edema can be created by various types of tourniquets (elastic bandage, scarf, adhesive, etc.). The best known clinical presentation in this sub-type of "hysterical blue edema" described by Charcot in 1889;
- finger and hand deformities: The most well-known factitious disorders of this type are "clenched fist syndrome" or "psycho-flexed hand" [8], corresponding to abnormal postures and rigidity of the fingers [1].

In 2007, Eldridge et al. added a 4th category corresponding to psychopathological sensory abnormalities and psychopathological complex regional pain syndrome [4].

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