

Factitious Disorders in Neurology: An Analysis of Reported Cases

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Background: *Factitious disorder (FD) is the deliberate production or simulation of symptoms in order to adopt the sick role. Objective:* *The authors look at FD in the neurology setting. Method:* *The authors examined documented, published cases. Results:* *FD cases in neurology are strikingly different from those in other specialties in terms of their demographics. Whereas the paradigm of FD in medicine as a whole is of the socially stable female healthcare worker, neurology continues to report largely the classic itinerant “Munchausen’s” type. Discussion:* *The authors explore two possible explanations for this: either that female healthcare workers with FD do not present neurologically, or that, if they do, they are diagnosed with conversion disorder.*
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Factitious disorder (FD) is the deliberate production or simulation of symptoms in order to adopt the “sick role.” The first generally accepted report was Asher’s description of “Munchausen’s disease,” in 1951,¹ and it first entered the diagnostic canon in 1980.² By this time, several case series had suggested that Asher’s description of peregrinating, antisocial patients applied to only a fraction of factitious cases: most cases were actually socially stable women working in the healthcare field. The dominant paradigm was not “the Munchausen’s patient,” but “the factitious nurse.”

From the outset, Asher described the neurological, along with the abdominal and the hematological, as the most familiar type of factitious presentation.¹ The beginnings of FD in neurology may considerably antedate Asher, however, particularly in its relationship with hysteria. A hundred years earlier, neurologists working with hysteria were struck by their patients’ ready transition to deliberate simulation in order to prolong their illnesses,^{2,3} and Freud formally blurred hysteria and FD when he claimed that there was a degree of conscious simulation in every case of hysteria.⁴ Today, many see FD and conversion disorder (as hysteria is now known) not as separate

categories, but as neighbors on a spectrum of simulated disorder,^{5–8} with the clinical distinction usually impossible to make.^{9,10}

The effect of this putative proximity with conversion disorder may be to make it an even less welcome diagnosis.¹¹ Its effect on factitious neurology is likely to be more complex, and is the subject discussed here. We would predict that FD diagnoses in neurology will have become less common over time, particularly where they might resemble conversion disorder. By examination of the published case reports, we shall consider how the proximity with conversion disorder may have influenced the diagnosis of factitious neurology. These reports tell us little about the true incidence of FD, but, particularly by comparison among specialties, they do tell us something about doctors’ behavior.

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METHOD

We searched PubMed online for new case reports or series of FDs presenting with primarily neurological symptoms, using the search terms Factitious or Munchausen, AND Neurology, Neurological, Neurosurgery, Neurosurgical, Paresis, -Plegia, -Aesthesia, Ataxia, Apraxia, Epilepsy, Seizure, Ache, Pain, or Coma. This was constructed to include any terms which were composed of the above, so that, for example, "Pseudoseizure" would be detected by the search for "Seizure." Further reports were sought by searching PubMed for articles that cited Asher,¹ and for articles related to Bauer et al.¹² Articles' references were manually searched for further cases. Cases were excluded if they were Munchausen-by-proxy, cited children, were historical, or where the primary symptoms could not be established. Cases were also excluded when it was ascertained that "factitious" was used in its more general sense of artificial, such as "factitious elevated potassium in a hemolyzed blood sample;" the judgment as to the factitious nature of the case was otherwise left with the authors' verdict. Where the authors reached no firm conclusion as to whether cases were factitious, they were excluded.

Where a history of repeated presentations was described, the presenting symptoms at the initial encounter with the authors were used. Where symptoms from multiple systems were included, the predominant group or the apparent diagnosis was used (for example, the case where a "38-year-old female physician was admitted with the suspected diagnosis of a myelodysplastic syndrome . . . [on] physical examination, neurological and dermatological disorders could be found. . ." ¹³ was taken to be hematological). Where no apparent diagnosis was available (e.g., Bauer and Boegner,¹² Case 1), we included those cases where neurological symptoms comprised a major part of the presentation but where no one system predominated.

Deciding which disorders were neurological also took some thought. For example, dementias are treated both by psychiatrists and neurologists, and "blackouts" can have a variety of causes, of which neurological and cardiac are only the commonest. We decided such issues on the basis of which specialties were likely to have initially managed the patients and consulted a neurologist where there was doubt; so, in the above conditions, we took pseudodementias to be psychiatric, because they are more commonly managed by psychiatrists, and pseudoblackouts to be neu-

rological, because they are commonly associated with other pseudoneurological symptoms, and, therefore, managed by neurologists.

A second search was conducted, to explore the proportion of cases that were neurological over the last 5 years compared with the earliest period of factitious cases. This comprised a search of PubMed for every case of FD, irrespective of presentation, restricted to the periods 2001–2005 and 1951–1965, using the terms Factitious, Artefact, or Munchausen, and using the exclusion criteria above. The earlier period was extended to 15 years because so few cases were found when only 5 years were considered.

RESULTS

A total of 45 reports, comprising 90 cases with neurological presentations of FD, were found.^{7,12,14–56} A wide range of neurological presentations were included, the commonest being functional motor symptoms/simulated strokes, and seizures/blackouts; see Table 1 for the numbers and types of presentation.

Some of the demographics of the neurological cases were unusual when compared with other large samples of general factitious patients,^{57–62} although it should be emphasized that demographic information was only available for a subset of our cases. Although the ages (16–62; mean: 34), and marital status of the neurological cases (9 single, 8 married, 2 divorced) were very similar to the general series (total mean age: 33; marital status: 55%

TABLE 1. Neurological Presentations of Factitious Disorder

Presentation	Cases, N
Epilepsy ^a	19
Sub-arachnoid hemorrhage	3
Meningitis	4
Cycloplegia	2
Head injury	3
Back injury	6
Weakness ^b	28
Dystonia	2
Apraxia	7
Anesthesia	7
Neuralgia ^c	7
Meniere's disease	1
Deafness	3
Reflex sympathetic dystrophy	7
Mixed	3
Total	87

^aIncludes "blackouts." ^bIncludes cases reported as strokes or only as "motor conversion."

^cIncludes cases of neck or back pain.

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