

FACTITIOUS DISORDER WITH OLIGOANURIA: A CASE REPORT

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ABSTRACT

A 12-year-old girl presented with complaint of passing very 'scanty' amount of urine, approximately 50 ml every alternate day for the last five years. She had been admitted for investigations several times in different hospitals in the past. On evaluation, she was found to have no abnormality related to the urinary tract. Detailed psychiatric assessment revealed the factitious nature of her symptoms, suggesting the diagnosis of factitious disorder with physical symptoms.

Key words : Factitious disorder, Munchausen's syndrome, oliguria, oligoanuria

Factitious disorders, with the classically named Munchausen's syndrome, being the best studied, represent some of the most disturbing, bewildering and frustrating presentations in psychiatric or medical practice. In the original description by Asher (1951) Munchausen's syndrome has been described as a chronic, factitious disorder with characteristic symptoms of knowingly repeated simulation of physical illness for the sole purpose of obtaining medical care and attention. There is usually no other recognisable motive as would be evident in case of malingering. Patients have feigned various medical illnesses like asthma, fever (Petersdorf & Bennett, 1957) and seizure (Ireland et al., 1967). In literature, genitourinary system - related Munchausen's syndrome has been reported as haematuria (Black, 1981) or renal colic. Munchausen's syndrome presenting with oliguria is very rare and only one such case has been reported by one of the authors previously (Agarwal et al., 1995).

CASE REPORT

A 12-year-old girl presented with chief complaint of passing 'little' amount of urine, approximately 50 ml every alternate day for the last five years. She had no complaint of oedema over feet, facial puffiness, haematuria, renal colic

or excessive sweating. Her attendants revealed that she has had a few episodes of hyperventilation and palpitation during the past one year; however these were not her major complaints. There was no past history of any psychiatric illness, drug dependence or any surgical intervention. She had been admitted in different hospitals on several occasions for the evaluation of oliguria. Every time, it had been explained to the patient's guardians that she was free from any physical illness.

She had undergone several investigations in the past. These revealed that urinalysis was normal; blood urea was 17 mg/dl and serum creatinine was 0.4 mg/dl. Her ultrasound abdomen revealed normal-sized kidneys with no evidence of hydronephrosis, scarring or calculus disease. She had also undergone intravenous urography which was found to be normal. Echocardiography revealed minimal mitral valve prolapse; otherwise it was normal.

She was admitted in our hospital for further evaluation. General physical examination revealed that she was thin-built, calm and gentle in behaviour. She had no pedal oedema or facial puffiness and her blood pressure was 116/80 mm Hg. Her cardiovascular examination revealed midsystolic click. Rest of the systemic examination was unremarkable.

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Detailed psychiatric evaluation was done during the hospital stay. The patient belonged to an upper middle class nuclear family consisting of parents and one elder sister. Her father was a successful businessman with little understanding about the psychological mechanisms associated with her illness. Her mother, a housewife had multiple somatic symptoms for several years, for which she had undergone detailed investigations in Nepal as well as India which did not reveal any abnormality. However, she had been receiving anti-anxiety and antidepressant medication for many years prescribed by various doctors which she believed to be cardiac medicines. Temperamentally, she was high-strung woman who enforced strict toilet-training on her children. Till date, she insisted on both her grown-up daughters to evacuate urinary bladder every time before leaving the house and frequently she would insist on physically verifying the fact of voiding of urine.

Premorbidly, the patient was described by her parents as having a 'weak heart', since she would easily get anxious and was prone to easy crying spells on trivial matters. Otherwise, her early childhood was unremarkable and there was no history of temper tantrums, bed-wetting, nightmares, night terrors etc. There was no history of sustained anxiety symptoms or mood changes or any remarkable change in her biological functions. She was an average student and attended school regularly other than the days when she was visiting hospital for various investigations. Since the onset of present problem of 'oliguria' for five years, the patient has had a few episodes of hyperventilation.

Investigations done during her hospital stay revealed that her blood urea was 18 mg/dl and serum creatinine was 0.4 mg/dl. Routine urinalysis showed no evidence of proteinuria, glycosuria and microscopic examination of centrifuged urine specimen was also normal. Urine specific gravity was 1.016. Overnight fluid deprivation test revealed that concentrating capacity of kidneys was normal. Haematological investigations showed Hb-13.1 g/dl, TLC-4,600/cmm, DLC-P₅₆ L₄₀ M₃ E₁

During hospitalization, initially the patient was generally cooperative and was willing to talk about her illness. She did not exhibit any clear attention-seeking, demonstrative, anxious or depressive behaviour. She did not complain of any disability or distress arising out of her symptomatology. She was asked to ingest liberal amounts of fluids and collect total amount of urine passed during the whole day. First day, she collected only 150 ml urine. Next day, her mother was instructed to accompany her for supervising reliable collection of urine. Total urine collected on this day was 550 ml. However, the patient showed lot of resistance to this and developed two episodes of hyperventilation and also complained of pain in the suprapubic region. She also resented psychological interviews when attempt was made for her to understand that inspite of her long-standing complaints, the physical investigations are normal and hence there was no major or serious physical disorder. Next day, she was catheterized and 24 hour urine was collected which was 1030 ml. At this point, she started showing clear anxiety symptoms, and became uncooperative for any further psychiatric interviews or intervention and her father also became hostile. The patient and her family demanded discharge against medical advice. Thereafter, she was sent home with advice to take alprazolam 0.25 mg three times a day. She came after one week for follow up. It was revealed that at home she did not have any episode of hyperventilation. However, she still complained of 'oliguria' for the past three days.

DISCUSSION

The fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has made a number of changes from the revised third edition of (DSM-III-R) in the classification and criteria for factitious disorders. DSM-III-R outlined separate set of criteria for factitious disorders with physical symptoms, or psychological symptoms or both. DSM-IV has merged the disorders into a single criteria set, labeled factitious disorders, and has delineated three subtypes: factitious disorders with predominantly psychological signs and

symptoms, factitious disorders with predominantly physical signs and symptoms, and factitious disorders with combined psychological and physical signs and symptoms. In malingering, person does have a clear cut motive, but in this case there was no long term motive other than getting hospitalized, which is typical of factitious disorder. The present case fulfills the diagnostic criteria of factitious disorder with physical symptoms.

The psychopathology of factitious disorders is unclear. Currently, it is believed that factitious disorders probably represent a final common pathway for maladaptive behaviour in certain vulnerable persons. Situation and causes leading to maladaptive behaviour manifested as factitious disorders are variable like inadequate emotional environment during childhood (Ireland et al., 1967), wish to be the center of interest and attention in dramatic role of patient (Asher, 1951; Chapman, 1957), grudge against doctor and hospital (Asher, 1951; Chapman, 1957), previous mental trauma and cultural disadvantage (Naish, 1979), aggression turned against the self, especially in polysurgery patient (Meninger, 1934).

Treatment of this condition is determined by the underlying psychiatric defect. There have been no adequate therapeutic trials since very few patients have undergone specific treatment for factitious disorder itself. There is little information regarding the long term prognosis of such patients.

The present case had history of several admissions; she had undergone several investigations; all these were futile and caused lot of inconvenience, wastage of time and money of the patient and her family members. This patient highlights the need to consider factitious disorder as one of the differential diagnosis, whenever a bizarre insoluble clinical problem is confronted, so

that unnecessary, extensive, expensive, invasive investigations and treatment can be avoided.

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