CHAPTER 104

Factitious Disorders and Malingering

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PRINCIPLES

Patients may present to the emergency department (ED) with symptoms that are simulated or intentionally produced. The reasons that cause this behavior define two distinct varieties: factitious disorders and malingering.

Factitious disorders are characterized by symptoms or signs that are intentionally produced or feigned by the patient in the absence of apparent external incentives.[1,2] Factitious disorders have been present throughout history. In the second century, Galen described Roman patients inducing and feigning vomiting and rectal bleeding.[3] Hector Gavin sought to categorize this behavior in 1834.[3] These patients constitute approximately 1% of general psychiatric referrals, but this percentage is lower than that seen in emergency medicine because these patients rarely accept psychiatric treatment.[1,4] Of patients referred to infectious disease specialists for fever of unknown origin, 9.3% of the disorders are factitious.[5] Between 5% and 20% of patients observed in epilepsy clinics have psychogenic seizures, and the number reaches 44% in some primary care settings.[6] Among patients submitting kidney stones for analysis, up to 3.5% are fraudulent.[7]

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) classifies factitious disorders into two types: factitious disorder imposed on self (FDIS) and factitious disorder imposed on another (FDIA).

Munchausen syndrome, the most dramatic and exasperating of the FDIS, was originally described in 1951.[8] This fortunately rare syndrome takes its name from Baron Karl F. von Munchausen (1720 to 1797), a revered German military officer and noted raconteur who had his embellished life stories stolen and parodied in a 1785 pamphlet.[3] The diagnosis applies to only 10% to 20% of patients with factitious disorders.[1,9] Other names applied include the "hospital hobo syndrome" (patients wander from hospital to hospital seeking admission), peregrinating (wandering) problem patients, hospital addict, polysurgical addiction, and hospital vagrant.[4,10]

FDIA, an especially pernicious variant that involves the simulation or production of factitious disease in children by a parent or caregiver, was first described in 1977.[2,11] There are approximately 1200 estimated new cases of FDIA per year in the United States.[3] The condition excludes straightforward physical abuse or neglect and simple failure to thrive; mere lying to cover up physical abuse is not FDIA.[3,11] The key discriminator is motive: the mother is making the child ill so that she can vicariously assume the sick role with all its benefits. The mortality rate from FDIA is 9% to 31%.[12] Children who die are generally younger than 3 years old, and the most frequent causes of death are suffocation and poisoning.[13] Permanent disfigurement or permanent impairment of function resulting directly from induced disease or indirectly from invasive procedures, multiple medications, or major surgery occurs in at least 8% of these children.[13,14] Other names applied include *Polle's syndrome* (Polle was a child of Baron Munchausen who died mysteriously), *factitious disorder by proxy, pediatric condition falsification, Munchausen syndrome by proxy,* and *Meadow's syndrome.*[3,8,10,12]

Malingering is the simulation of disease by the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives, such as avoidance of military conscription or duty, avoidance of work, obtainment of financial compensation, evasion of criminal prosecution, obtainment of drugs, gaining of hospital admission (for the purpose of obtaining free room and board), or securing of better living conditions.[2,8,15] The most common goal among such "patients" presenting to the ED is to obtain drugs, whereas in the office or clinic the gain is more commonly insurance payments or industrial injury settlements. The true incidence of malingering is difficult to gauge because of underreporting, but estimates include a 1% incidence among mental health patients in civilian clinical practice, 5% in the military, and as high as 10% to 20% among patients presenting in a litigious context.[8,9] The most likely conditions to be feigned are mild head injury, fibromyalgia, chronic fatigue syndrome, and chronic pain.[9,15]

CLINICAL FEATURES

Factitious Disorders

Factitious Disorders Imposed on Self

The diagnosis of FDIS depends on specific criteria (Box 104.1).[2] With a factitious disorder, the production of symptoms and signs is compulsive; the patient is unable to refrain from the behavior even when its risks are known. The behavior is voluntary only in the sense that it is deliberate and purposeful (intentional) but not in the sense that the acts can be fully controlled.[2] The underlying motivation for producing these deceptions, securing the sick role, is primarily unconscious.[6,8,9] Individuals who readily admit that they have produced their own injuries (eg, self-mutilation) are not included in the category of factitious disorders.[9] Presentations may be acute, in response to an identifiable recent psychosocial stress (termination of romantic relationship, threats to self-esteem), or a chronic life pattern, reflective of the way in which the person deals with life in general.[9] The symptoms involved may be either psychological or physical.

Psychological Symptoms. This disorder is the intentional production or feigning of psychological (often psychotic) symptoms suggestive of a mental disorder. Stimulants may be used to induce restlessness or insomnia; hallucinogens, to create altered levels of consciousness; and hypnotics, to produce lethargy. This psychological factitious condition is less common than factitious disorders with physical symptoms and is almost always superimposed on a severe personality disorder.[2,9]

Physical Symptoms. The intentional production of physical symptoms may take the form of fabricating of symptoms without signs (eg, feigning abdominal pain), simulation of signs suggesting illness (eg, fraudulent pyuria, induced anemia), self-inflicted conditions (eg, the production of abscesses by injection of contaminated material under the skin), or genuine complications

BOX 104.1

DSM-5 Criteria for the Diagnosis of Factitious Disorder Imposed on Self

1. Falsification of psychological or physical signs or symptoms, or induction of disease or injury associated with identified deception.
2. The individual presents to others as injured, ill, or impaired.
3. The deceptive behavior is apparent even in the absence of external incentives.
4. The behavior is not better explained by another mental disorder.

from the intentional misuse of medications (eg, diuretics, hypoglycemic agents).[7,10,11,15] These patients are predominantly unmarried women younger than 40 years old. They typically accept their illness with few complaints and are generally well-educated, responsible workers or students with moral attitudes and otherwise conscientious behavior.[9,15,16] Many are in health care occupations, including nurses, aides, and physicians.

These patients are willing to undergo incredible hardship, limb amputation, organ loss, and even death to perpetuate the masquerade.[10,15] Although multiple hospitalizations often lead to iatrogenic physical conditions, such as postoperative pain syndromes and drug addictions, patients continue to crave hospitalization for its own sake. They typically have a fragile and fragmented self-image and are susceptible to psychotic and even suicidal episodes.[15,16] Interactions with the health care system and relationships with caregivers provide the needed structure that stabilizes the patient's sense of self. The hospital may be perceived as a refuge, sanctuary, or womblike environment.[15,16] Some patients are apparently driven by the conviction that they have a real but as yet undiscovered illness. Consequently, artificial symptoms are contrived to convince the physician to continue a search for the elusive disease process.[15,16] Factitious illness behavior has even emerged on the Internet. "Virtual support groups" offering person-to-person communications through chat rooms and bulletin boards have been perpetrated by individuals, under the pretense of illness or personal crisis, for the purpose of extracting attention or sympathy, acting out anger, or exercising control over others.[8]

Approach to Diagnosis. The initial diagnosis of FDIS is often delayed because the possibility of factitious disease is not considered, physicians may be unfamiliar with this problem, or the patient does not exhibit the type of personality expected with this behavior.[9] Diagnosis may be confounded by genuine medical illnesses predating and coexisting with a factitious disorder. For example, patients with factitious hypoglycemia may have a history of insulin-dependent diabetes mellitus, or factitious skin disorders may be preceded by true dermatologic diseases.[1,15] Identification of a factitious disorder is usually made in one of four ways: (1) the patient is accidentally discovered in the act, (2) incriminating items are found, (3) laboratory values suggest nonorganic etiology, or (4) the diagnosis is made by exclusion.[4,7]

There has been increasing recognition of factitious illness produced by children. These children, ranging in age from 8 to 18 years old, are typically "bland, flat and indifferent during their extensive medical interventions … depressed, socially isolated, and often obese."[13] Among the most common presentations are fever without clear etiology, diabetic ketoacidosis, purpura, and recurrent infections. The prognosis is good if identification and psychotherapeutic intervention can be carried out at a young age.[12]

Munchausen Syndrome. The uncommon patient with true Munchausen syndrome has a prolonged pattern of "medical imposture," usually years in duration. The behavior usually begins before 20 years old and is diagnosed between 35 and 39 years old. Twice as many men as women are affected.[8,15,16] Patients' entire adult lives may consist of trying to gain admission to hospitals and then steadfastly resisting discharge. Their career of imposture usually lasts about 9 years but has continued unabated for as long as 50 years.[4,15] The quest for repeated hospitalizations often takes these patients to numerous and widespread cities, states, and countries.[2,8]

These individuals see themselves as important people, or at least related to such persons, and their life events are depicted as exceptional.[16] They possess extensive knowledge of medical terminology. There is frequently a history of genuine disease, and the individual may exhibit objective physical findings.[16]

The symptoms presented are "limited only by the person's medical knowledge, sophistication, and imagination."[2] The alleged illnesses involved have been termed *dilemma diagnoses* in that investigators rarely can totally rule out the disorder, clarify the cause, or prove that it did not exist at one time.[4] Common presentations are those that most reliably result in admission to the hospital, such as abdominal pain, self-injection of a foreign substance, feculent urine, bleeding disorders, hemoptysis, paroxysmal headaches, seizures, shortness of breath, asthma with respiratory failure, chronic pain, acute cardiovascular symptoms (eg, chest pain, induced hypertension and syncope), renal colic and spurious urolithiasis, fever of unknown origin (hyperpyrexia figmentatica), profound hypoglycemia, and coma with anisocoria.[4-6,10,15,16] Some self-induced conditions are highly injurious or even lethal.[10]

The patient usually presents during evenings or on weekends so as to minimize accessibility to psychiatric consultants, personal physicians, and past medical records.[16] In teaching institutions, these patients often present in July, shortly after the change in resident house officers.[10] They relate their history in a precise, dramatic, even intriguing fashion, embellished with flourishes of pathologic lying and self-aggrandizement. *Pseudologia fantastica,* or pathologic lying, is a distinctive peculiarity of these patients. In a chronic, often lifelong behavior pattern, the patient typically takes a central and heroic role in these tales, which may function as a way to act out fantasy.[17] The history quickly becomes vague and inconsistent, however, when the patient is questioned in detail about medical contacts.[3] Attempts to manage the complaint on an outpatient basis are adamantly resisted.[15] Once admitted, the patient initially appeals to the physician's qualities of nurturance and omnipotence, lavishing praise on the caregivers. Behavior rapidly evolves, however, as the patient creates havoc on the ward by insisting on excessive attention while ignoring both hospital rules and the prescribed therapeutic regimen.[15] When the hoax is uncovered and the patient confronted, fear of rejection abruptly changes into rage against the treating physician, closely followed by departure from the hospital against medical advice.[15,18]

Factitious Disorder Imposed on Another

The diagnosis of FDIA depends on specific criteria (Box 104.2).[2] The presenting complaints typically evade definitive diagnosis and are refractory to conventional therapy for no apparent reason.[19] The symptoms are usually more than five in number, presented in a confused picture; they are unusual or serious and, by design, unverifiable. They invariably occur when the mother is alone with the child or otherwise unobserved.[12] In 72% to 95% of cases, simulation, or production of illness occurs while the victim is hospitalized.[11,12,14]

Simulated illness, faked by the mother without producing direct harm to the child (eg, the addition of blood to a urine

BOX 104.2

DSM-5 Criteria for the Diagnosis of Factitious Disorder Imposed on Another

1. Falsification of psychological or physical signs or symptoms, or induction of disease or injury in another, associated with identified deception.
2. The individual presents another individual (victim) to others as injured, ill, or impaired.
3. The deceptive behavior is apparent even in the absence of external incentives.
4. The behavior is not better explained by another mental disorder.

BOX 104.3

Characteristics of Malingering

1. Medicolegal context of the presentation (eg, the patient was referred by his or her attorney)
2. Marked discrepancy between the person's claimed stress or disability and objective findings
3. Poor cooperation during the diagnostic evaluation or poor compliance with previously prescribed treatment regimens
4. The person exhibits or has a history of antisocial behavior

specimen), is present in 25% of cases. Produced illness, which the mother actually inflicts on the child (eg, the injection of feces into an intravenous line), is found in 50% of cases. Both simulated and produced illnesses are found in 25% of cases.[11-14]

FDIA most commonly arises with factitious bleeding, seizures, central nervous system (CNS) depression, apnea, diarrhea, vomiting, fever, and rash.[14] Reported techniques of simulation or production of disease include administration of drugs or toxins (eg, chronic arsenic poisoning, ipecac, warfarin, phenolphthalein, hydrocarbons, salt, imipramine, laxatives, CNS depressants), caustics applied to the skin, and nasal aspiration of cooking oil.[11,14,18] Techniques of asphyxiation include (1) covering the mouth or nose with one or both hands, a cloth, or plastic film, and (2) inserting the fingers into the back of the mouth. In such instances, even struggling infants may sustain no cutaneous markings.[19] Cases involving seizures are common and may involve third-party witnesses. On personal questioning, however, these witnesses frequently deny the occurrence of seizure activity.[6,13,14]

Perpetrator Characteristics. Ninety-eight percent of perpetrators are biologic mothers who come from all socioeconomic groups.[11-14] Many have a background in health professions or social work, or a past history of psychiatric treatment, marital problems, or suicide attempts.[11-15] Depression, anxiety, and somatization are common, but frank psychotic behavior by the mother is atypical.[14] Perpetrators of FDIA have an inherent skill in manipulating health care workers and child protection services.[13] They are pleasant, socially adept, cooperative, and appreciative of good medical care. They often display a peculiar eagerness to have invasive procedures performed on their child.[3] They often prefer to stay in the hospital with their child, cultivate unusually close relationships with hospital staff, and thrive on staff attention.[11-14] This affable relationship with the medical team rapidly changes to excessive anger and denial when the perpetrator is confronted with suspicions.[12,13]

Most of these mothers have had an abusive experience early in life, and they use the health care system as a means to satisfy personal nurturing demands.[3,12] They often cannot distinguish their needs from the child's and satisfy their own needs first. They derive a sense of purpose from the medical and nursing attention gained when their children are in the hospital.[11-13] Alternatively, the behavior may enable the mothers to escape from their own physical or psychological illnesses, marital difficulties, or social problems.[13]

Victim Characteristics. Victims of FDIA are equally male and female children. The mean age at diagnosis is 40 months, and the mean duration from the onset of signs and symptoms to diagnosis is 15 months.[11-13] A known physical illness that explains part of the symptoms is common among these children.[13] Most have a history of significant failure to thrive and have been hospitalized in more than one institution. Delays in many areas of performance and learning, difficulty with family relationships, attention deficit disorder, or clinical depression may coexist.[13] Some of these victims may have factitious disorder later in life.[3] Elders may also be victims of FDIA, although this is uncommon.[20]

Approach to Diagnosis. Suspected FDIA requires a detailed description of the event or illness and a search for caregiver witnesses, who should be interviewed personally. Although it is essential to see the child when the symptoms are present, the parents show great ingenuity at frustrating this effort.[12,13] Additional history of unusual illness in siblings and parents should be sought. Child victims who are verbal should be interviewed in private about foods, medicines, and their recollection of the symptoms or events. Prior medical records of the victim and, if possible, the siblings should be examined, although parents may impede such data gathering.

The major obstacle to early discovery of FDIA is its omission from the differential diagnosis. When it is considered, the diagnosis is generally made easily and quickly.[11-13] A suspected diagnosis may be confirmed through separation of the parent from the child or individual (with consequent cessation of symptoms), covert video surveillance during hospitalization, or toxicologic screens.[16] In the majority of cases, the caregiver attempts to induce episodes surreptitiously while in the hospital, often during the first day of admission.[11-13]

Malingering

Malingering is frequently found in association with antisocial personality disorder. On questioning, malingerers are vague about prior hospitalizations or treatments. The physicians who previously treated them are usually unavailable. At times, malingerers may be careless about their symptoms and abandon them when they believe no one is watching.[8] In some "patients," such as those seeking drugs, homeless persons seeking hospital admission on a cold night, or prisoners wanting a holiday from incarceration, the secondary gain may be clear. In other persons, the external incentive may be obscure.

In contrast to the person with factitious disorders, the malingerer prefers counterfeit mental illness, because it is objectively difficult to verify or to disprove. Amnesia is the most common psychological presentation, followed by paranoia, morbid depression, suicidal ideation, and psychosis.[15]

Malingering should be strongly suspected with any combination of certain factors (Box 104.3).[2] A definitive diagnosis of malingering is rare and can be established only with the patient's confession.[3] Because malingering constitutes criminal behavior, documentation of this diagnosis should be made with care.[15] In the absence of proof of wrongdoing, it is best to assume that the

patient is not a malingerer but rather a common somatizer.[15] Malingerers who pursue drugs may report an unusually large number of drug allergies to persuade the physician to prescribe their drug of choice or simply insist on a specific drug (eg, meperidine [Demerol] or hydromorphone [Dilaudid]).[8] Unfortunately, the Internet offers a wide availability of quality medical advice on how to convincingly feign pain and disability.

DIFFERENTIAL DIAGNOSIS

The most important diagnoses to be excluded are genuine medical and psychiatric conditions that might account for the presenting symptoms. Patients with conversion disorder, somatic disorder, delusional disorder of somatic type, and borderline personality disorder can present with symptoms similar to FDIS. The differences can be subtle and psychiatric consultation or referral is indicated.

Patients with factitious disorders are distinguished from malingerers because their desired hospitalization or surgery seems to offer no secondary gain other than to play the sick role.[2,10,15] The clinical presentation of the majority of patients with factitious disorders, unlike those with Munchausen syndrome, is relatively subtle and convincing. The complaints are generally chronic in nature rather than emergent and precipitous, and there are no obvious associated behavioral aberrations.[15] The chronicity of malingering is usually less than that associated with factitious disorder, and malingerers are more reluctant to accept expensive, possibly painful, or dangerous tests or surgery.[15]

MANAGEMENT

Factitious Disorders

Treatment options for factitious disorders depend on the patient's characteristics. Although it is challenging, management of common forms of factitious disorder can be more rewarding, especially with adolescents, than management of Munchausen syndrome.[11,15] The prognosis is more favorable for cases with an underlying depression than for those associated with borderline personalities.[11,14]

The best approach to patients with factitious disorder, other than Munchausen syndrome and FDIA, is controversial. Direct non-accusatory confrontation has been advocated as "the foundation of effective management" when it is coupled with the assurance that an ongoing relationship with a physician will be provided.[11,13,15] This may be the first step in the acceptance of outpatient therapy.[15]

Others point out that confrontation is ineffective in most patients and may even be counterproductive in that it threatens to undermine a needed psychological defense. Enforced recognition of external objective reality, while simultaneously disallowing the patient's subjective experience, may generate even more dysfunction directed at legitimizing and maintaining symptoms and may even place the patient at risk for suicide.[11,15] Some patients may relinquish this defense if they feel safe in doing so and may abandon a claim to disease if some face-saving option is offered. This approach, termed the *therapeutic double bind* or *contingency management,* involves informing the patient that a factitious disorder may exist. The patient is further told that failure to respond fully to medical care would constitute conclusive evidence that the patient's problem is not organic but rather psychiatric. The problem is therefore reframed or redefined in such a way that (1) symptoms and their resolution are both legitimized and (2) the patient has little choice but to accept and respond to a proposed course of action or seek care elsewhere.[15]

Individuals with Munchausen syndrome typically demonstrate overt sociopathic traits or a borderline personality disorder and are demanding and manipulative, especially regarding analgesics.[15] They have been described as "essentially untreatable," and successful management of this condition is, in fact, considered reportable. Early confrontation or limit setting, especially regarding drug use, is advocated.[8,10,15] Although Munchausen patients typically do not want to be examined extensively, a thorough physical examination should be performed to rule out physical disease.

FDIA constitutes a form of child (or elder) abuse, and appropriate action to protect the victim, including notification of state social service agencies, should take immediate priority.[13,14] If available, a pediatrician who has expertise in child abuse should assess the case. When the diagnosis has been established and the parents have been confronted, psychiatric care should be made immediately available to the parents because maternal suicide is a significant risk.[13,15]

Malingering

Malingerers do not want to be treated. Because they are "gaming the system" for personal advantage, the last thing they want is an accurate identification of their behavior and appropriate intervention. The emergency clinician should maintain clinical neutrality, offering the reassurance that the symptoms and examination are not consistent with any serious disease.

Some authors have characterized patients' use of medical resources under false pretenses as criminal behavior, and several states have enacted legislation against the fraudulent acquisition of medical services with successful prosecution of such behavior.[4,8] Conversely, patients with factitious disorders can and do sue. In dealing with such patients, it is advisable to involve hospital administration and risk management. Clandestine searches are inadvisable, and respect for the patient's confidentiality should be maintained.[15]

DISPOSITION

Patients suspected of having a factitious disorder should be referred for primary care follow-up, and if it is acceptable to the patient, psychiatric referral should also be arranged. Referral to other medical specialists or hospitalization should be avoided when possible.

The manner of presentation and the unavailability of past medical history often allow patients with Munchausen syndrome to achieve hospital admission. If the patient is discharged from the ED, outpatient primary care follow-up and psychiatric referral should be offered, although both are likely to be refused.[15]

Because perpetrators of FDIA typically induce symptomatic episodes soon after hospitalization, admission of the victims (children or elders) without taking appropriate precautions may actually place them at increased risk.[11,13,20] Visits by the suspected perpetrator should be closely supervised, and no food, drink, or medicines should be brought in by the family. Protective services should be notified. Out-of-home placement of children in established cases of FDIA is advisable, and the best outcomes are seen among children taken into long-term care at an early age without access to their mother. Children allowed to return home have a high rate of repeated abuse.[3,12] In 20% of reported deaths, the parents had been confronted and the child sent home to them, subsequently to die.[12,13]

After courteous but assertive reassurance, suspected malingerers should be offered primary care follow-up if the symptoms do not resolve. These individuals may become threatening when they are either denied treatment or overtly confronted.[15]

KEY CONCEPTS

- Patients who have consciously synthesized symptoms and signs may be divided into two broad diagnostic categories: (1) those with obvious secondary gain (malingering), who control their actions, and (2) those with a motivation of achieving the sick role (factitious disorders), who cannot control their actions.
- The initial management of patients suspected of fabricating disease should include a caring, nonjudgmental attitude and a search for objective clinical evidence of treatable medical or psychiatric illness. Review of old medical records and interview of family members are often helpful.
- Unnecessary tests, medications, and hospitalizations should be avoided in the absence of objective evidence of a medical or psychiatric disease, and patients should be referred for ongoing primary care.
- In cases of suspected FDIA involving children or elders, protection of the victim takes first priority.

The references for this chapter can be found online by accessing the accompanying Expert Consult website.

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CHAPTER 104: QUESTIONS & ANSWERS

104.1. Which of the following statements regarding factitious disorder is true?
- **A.** It involves voluntary and controllable symptom production.
- **B.** Patients are generally well educated and otherwise responsible.
- **C.** Presentations are not related to an identifiable event.
- **D.** The symptoms produced are always physical ones.
- **E.** The underlying motivation is a conscious one.

Answer: B. Many such patients are actually employed in the health care industry. The act of producing symptoms is voluntary but not controllable and derives from a subconscious motivation. Presentations are very often related to a "traumatic" event, such as a breakup. Produced symptoms may be physical (eg, hematuria) or psychological. The typical patient is an unmarried female younger than 40 years. Despite undergoing invasive procedures and associated hardships, these patients seek more medical care and hospitalization.

104.2. Which of the following statements concerning Munchausen syndrome by proxy is true?
- **A.** A known physical illness in the child is common.
- **B.** Most maternal perpetuators are demanding, uncooperative, and socially inept.
- **C.** Most maternal perpetrators are not a biologic parent.
- **D.** Psychosis is common in the maternal perpetrator.
- **E.** The mean age of victim diagnosis is 7 to 9 years.

Answer: A. Victim children often have a legitimate illness. Mean age at diagnosis is 40 months. Most have a history of failure to thrive and multiple hospitalizations. The perpetrator receives some personal fulfillment from the care and attention of the hospital staff, which is often admiration for her persistence, willingness to sacrifice and patience, and she is typically pleasant, medically savvy, and socially skilled. Invasive procedures on the child are often welcomed. Although psychosis is very unusual in the parent, depression, anxiety, and somatization are typical in the perpetrator.

104.3. A 2-year-old female presents with new onset seizures. Her past medical history is unremarkable. Laboratory evaluation reveals blood glucose of 20 mg/dL. The patient's mother denies a family history of diabetes or having medications the child might have ingested at home. She works as a nurse at a local hospital and has been with the child all day. The child's symptoms improve with glucose administration and a meal. Your colleague remembers evaluating the child recently for hematuria with a negative evaluation. If you suspect Munchausen syndrome by proxy, which of the following tests would be most helpful in establishing the diagnosis?
- **A.** Basic metabolic panel
- **B.** Computed tomography (CT) scan of head
- **C.** C-peptide and insulin level
- **D.** Electroencephalography (EEG)

Answer: C. The diagnostic criteria for factitious hypoglycemia include high serum insulin levels along with the absence of serum C-peptide. The C-peptide is removed during the purification of commercial insulin, and so its absence suggests the presence of endogenously administered insulin. In patients with insulinoma, both C-peptide and insulin levels are elevated and detectable.

104.4. A prison inmate presents after falling from the top bunk in his cell. He is complaining of lower lumbar pain and states he is unable to move or feel his lower extremities from his waist down. On physical examination, lower extremity reflexes are present but the patient denies feeling pain or light touch sensation below the waist. Lumbar spine CT and MRI are negative. Which of the following conditions is most likely?
- **A.** Cord contusion
- **B.** Factitious disorder
- **C.** Malingering
- **D.** Munchausen syndrome

Answer: C. Malingering is the intentional symptom production for secondary gain. There is a marked discrepancy between claimed disability and the actual objective findings. Confessions and proof are rare.