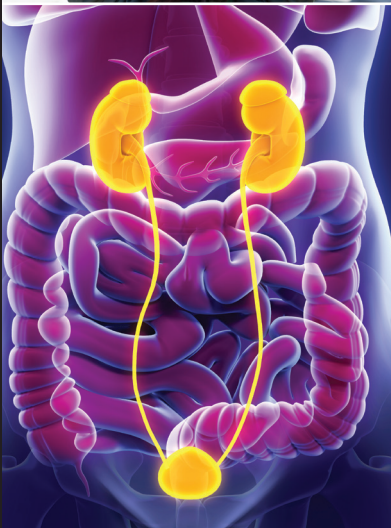
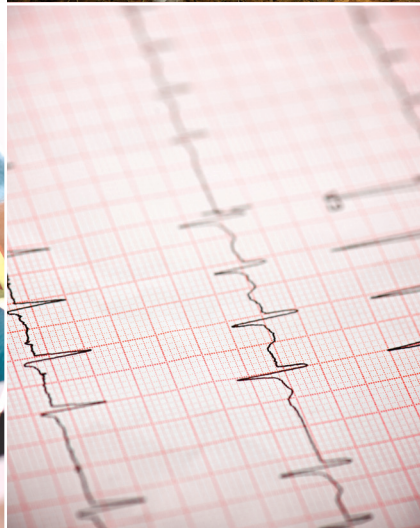


2025 Critical decisions in emergency medicine



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Handle With Care

In addition to severe pain from vaso-occlusive crises, individuals with sickle cell disease can suffer from many complications, including stroke, hepatic sequestration, aplastic anemia, and priapism. These complications can cause significant morbidity and mortality and compel patients to seek help from the emergency department. It is vitally important that emergency physicians recognize the complications of sickle cell disease and understand the nuances of managing these conditions.

Fact Checking

Although emergency physicians are primarily trained to identify life- and limb-threatening physiologic conditions, patients with psychobehavioral etiologies also present to the emergency department. Physicians must remain alert to the possibility that a patient could be simulating medical symptoms without any obvious external incentives in what is known as *factitious disorder imposed on self*. By recognizing and communicating red flags, emergency physicians can alert subsequent physicians to the situation, thereby helping patients get diagnosed sooner, experience improved outcomes, and appropriately use health care resources.



Individuals in Control of Content

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2. Madeline Dwyer, MD – Faculty
3. Varsha Goswami, MD – Faculty
4. Kelsey Hopkins, MD – Faculty
5. Alexander Kleinmann, MD – Faculty
6. Bernard L. Lopez, MD, MS, CPE, FACEP – Faculty
7. Prayag Mehta, MD – Faculty
8. Anjali Misra, MD, MPH – Faculty
9. Katherine Stewart, MD – Faculty
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EDITOR-IN-CHIEF

Danya Khoujah, MBBS, MEHP, FACEP
University of Maryland, Baltimore, MD
AdventHealth, Tampa, FL

SECTION EDITORS

William J. Brady, MD, FACEP
University of Virginia, Charlottesville, VA

Joshua S. Broder, MD, FACEP
Duke University, Durham, NC

Erika B. Crawford, MD, FAAP, FACEP
University of South Carolina School of Medicine,
Prisma Health — Upstate, Greenville, SC

Ann M. Dietrich, MD, FAAP, FACEP
University of South Carolina School of Medicine,
Prisma Health — Upstate, Greenville, SC

Andrew J. Eyre, MD, MS-HPed, FACEP
Brigham and Women's Hospital/
Harvard Medical School, Boston, MA

Frank LoVecchio, DO, MPH, FACEP
Valleywise, Arizona State University, University of Arizona,
and Creighton University School of Medicine, Phoenix, AZ

Diego Riveros, MD, CAQSM
University of South Florida Morsani College of Medicine,
Tampa, FL

Christian A. Tomaszewski, MD, MS, MBA, FACEP
University of California San Diego Health, San Diego, CA

Peter Vandersteenhoven, MD, MS
University of Virginia, Charlottesville, VA

Steven J. Warrington, MD, PhD
MercyOne Siouxland, Sioux City, IA

ASSOCIATE EDITORS

Tareq Al-Salamah, MBBS, MPH, FACEP
King Saud University, Riyadh, Saudi Arabia

Wan-Tsu W. Chang, MD
University of Maryland, Baltimore, MD

Kelsey Drake, MD, MPH, FACEP
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Walter L. Green, MD, FACEP
UT Southwestern Medical Center, Dallas, TX

John C. Greenwood, MD, MS
University of Pennsylvania, Philadelphia, PA

John Kiel, DO, MPH, FACEP, CAQSM
University of South Florida Morsani College of Medicine,
Tampa, FL

Nathaniel Mann, MD
University of South Carolina School of Medicine,
Greenville, SC

Amal Mattu, MD, FACEP
University of Maryland School of Medicine, Baltimore, MD

EDITORIAL STAFF

Joy Carrico, JD, Managing Editor
jcarrico@acep.org

Alex Bass
Associate Editor

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Associate Editor

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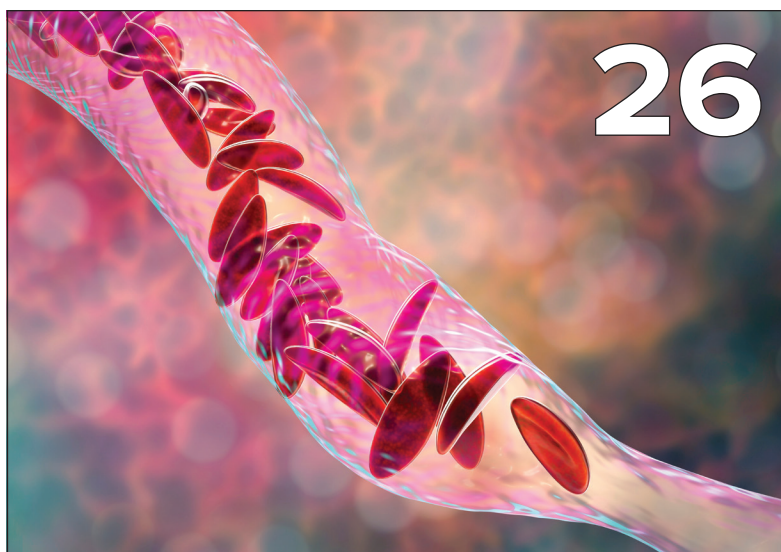
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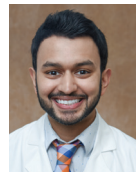
Reviewed by Christian A. Tomaszewski, MD, MS, MBA, FACEP



Fact Checking

Factitious Disorder in the Emergency Department

LESSON 1



By Eileen Williams, MD; and Prayag Mehta, MD

Dr. Williams is an emergency medicine resident and Dr. Mehta is an assistant professor and program codirector of the Advanced Practice Provider Postgraduate Certificate Program at the University of Texas Southwestern Medical Center in Dallas.

Reviewed by Danya Khoujah, MBBS, MEHP, FACEP

Objectives

On completion of this lesson, you should be able to:

1. Define factitious disorder and recognize common red flags that raise suspicion for this condition.
2. Differentiate factitious disorder from other conditions that present with similar features, including psychotic disorders, personality disorders, and substance use disorders.
3. Recognize the increased risk of adverse outcomes when factitious disorder is left off the differential diagnosis.
4. Discuss proper management techniques for patients who present with manifestations of factitious disorder.
5. Document concern for factitious disorder appropriately in the medical record.

From the EM Model

14.0 Psychobehavioral Disorders
14.3 Factitious Disorders

CRITICAL DECISIONS

- What is factitious disorder imposed on self?
- What is the differential diagnosis when considering factitious disorder?
- Why is it important to recognize possible presentations of factitious disorder?
- How should emergency physicians approach the treatment of patients with suspected factitious disorder?
- How should concern for factitious disorder be documented in the medical record?

Although emergency physicians are primarily trained to identify life- and limb-threatening conditions with physiologic etiologies, patients with psychobehavioral etiologies also present to the emergency department. Emergency physicians must remain alert to the possibility that a patient could be simulating or fabricating their medical symptoms without any obvious external incentives in what is known as *factitious disorder imposed on self*. By recognizing and communicating red flags, emergency physicians can alert subsequent physicians to the situation, thereby helping patients get diagnosed sooner, experience improved outcomes, and appropriately use costly health care resources.

CASE PRESENTATIONS

■ CASE ONE

A 23-year-old man presents via EMS from his job as a fitness instructor after collapsing in the middle of an exercise class. Witnesses report that he started shaking all over and his eyes rolled back in his head. After approximately 3 minutes, he stopped shaking and sat up, immediately alert and able to answer questions. He requested that someone in the class call 911. On EMS arrival, he informed the paramedic that he had a history of epilepsy. His vital signs were normal, and an 18-gauge intravenous line was placed in his left antecubital fossa. In the ambulance, he again became unresponsive and had an episode of urinary incontinence. He then developed generalized tonic-clonic movements of the extremities. EMS administered 4 mg of intravenous lorazepam, without any change in the patient's symptoms.

The patient arrives after 8 minutes of continuous seizure-like activity. On initial assessment, his eyes remain forcefully closed, and he is unresponsive to verbal stimuli. Given concern for status epilepticus, he immediately receives another 4 mg of intravenous lorazepam, again without response. On further examination, he has no intraoral trauma. A point-of-care venous blood gas analysis reveals a normal lactate level.

■ CASE TWO

A 32-year-old female critical care nurse is brought down to the emergency department by coworkers after an episode of syncope that was witnessed by another nurse. She had no seizure-like activity, tongue biting, or urinary incontinence. On arrival, the patient's finger-stick glucose level is checked, but the blood glucometer reads only "RR low." A dextrose injection is administered, and the patient subsequently regains consciousness. She immediately becomes tearful and asks that the physician remain at her bedside just in case. She states that she has been trying to decrease her glucose intake because she is afraid of developing diabetes. She lives with her sister, who has type 2 diabetes that requires insulin and multiple oral antidiabetic medications.

A broad laboratory workup is initiated, including blood cultures and lactate testing, given concern for an occult infection that could cause sepsis. Her lactate, thyroid-stimulating hormone, CBC, and electrolyte results are all normal. An ECG shows sinus tachycardia without acute ischemic change. After 20 minutes, the patient starts to become confused and less responsive. Her blood glucose level is 42 mg/dL, which improves to 82 mg/dL after a cup of juice. Grabbing a nurse by the hand, the patient again becomes tearful and expresses gratitude for the excellent medical care she has received. Her medical record reveals a history of similar emergency department presentations for complications of hypoglycemia without a personal history of diabetes. Her only medication on file is sertraline.

■ CASE THREE

A 57-year-old businessman presents via EMS from the airport for what he describes as crushing substernal chest pain. He lives in another state and has just arrived for a brief layover on his way to a professional conference. On arrival, he states that he had progressively worsening shortness of breath while walking to the gate. He then developed chest pains so severe that he had to stop and sit down, asking a passerby to call an ambulance. Currently, he reports ongoing pain, as well as associated nausea and diaphoresis. He says that the pain feels like "an elephant sitting on my chest" and that the pain radiates to his left arm. His ECG, vital signs, and initial troponin levels are within normal limits. The emergency physician is unable to access any external medical records from the patient's home health care system.

Introduction

Patients with factitious disorder imposed on self simulate or create symptoms of medical or psychological disease without a motivation for material gain. These patients frequently present for various complaints, and measures taken to treat their presenting symptoms are often ineffective thus placing significant strain on the health care system. It has been postulated that most physicians will encounter at least one patient with factitious disorder over the course of their careers, and research suggests that the rate of factitious disorder may be higher in complex patient populations or those with conditions that present diagnostic challenges — a demographic that includes many emergency department patients.¹ Therefore, understanding the common presentations of factitious disorder imposed on self and learning how to recognize red flags, build a differential diagnosis, and manage patients with this condition are important skills for every emergency physician.

CRITICAL DECISION

What is factitious disorder imposed on self?

Factitious disorder imposed on self is a psychiatric disorder in which affected individuals induce, simulate, or falsely report illness, injury, or impairment with no motivation to achieve secondary gain.² It is characterized by a pervasive pattern of volitional and deceptive acts intended to fabricate the appearance of illness, often resulting in pain and personal endangerment.³ Patients with factitious disorder imposed on self can exaggerate or lie about their symptoms, interfere with diagnostic studies, or induce true medical conditions. Multiple investigations have shown that, overall, these patients are more likely to induce illness or injury than to simulate or falsely report symptoms (*Table 1*).^{4,5}

Factitious disorder has a long and storied history. Munchausen syndrome was first recognized and named in 1951.⁶ Now considered a subtype of factitious disorder, the term Munchausen syndrome is used to describe an “evasive hospital hopper with a dramatic medical history.”⁶ In another pathologic variant, factitious disorder imposed on another, patients fabricate symptoms in or impose them on a second individual, usually a child or other dependent. Cases of pediatric factitious disorder, in which children independently simulate or create their own symptoms, have also been reported. Many existing resources offer insight into these proxy and pediatric presentations, which are beyond the scope of this discussion.^{7,8} For clarity and brevity, the term *factitious disorder* will be used hereinafter to indicate factitious disorder imposed on self in the adult population.

One seminal epidemiologic investigation of factitious disorder was conducted by Yates and Feldman in 2016.² In their systematic review, they examined over 450 known cases of factitious disorder. The majority (66.2%) occurred in female patients with a mean age of 34.2 years at diagnosis. Patients with factitious disorder were also disproportionately likely to report an occupational history in health care or laboratory services. Many reported receiving at least one additional psychiatric diagnosis, with the plurality (41.8%) reporting a current or prior diagnosis of depression.²

In 2023, a large retrospective study in France examined over 2,200 cases of factitious disorder identified in the hospital setting from 2009 to 2017. The study largely confirmed the previously published findings.⁵ Once again, most cases (58.2%) were diagnosed in female patients. However, the average factitious disorder patient in this investigation was found to be slightly older: 48.5 years was the mean age at diagnosis. Most patients (56.8%) were rehospitalized at least once in the year following their first presentation.⁸ Accordingly, it makes sense for physicians to increase their index of suspicion for this condition in patients with multiple recent presentations or hospitalizations.

Other features concerning for factitious disorder include implausible or highly unusual test results (eg, hypothermia to 28°C [82.4°F] in an otherwise well-appearing patient), contradictory laboratory results, unusual or inconsistent bacteriology (such as fecal bacteria in a distant skin lesion), and an extremely protracted yet atypical disease course.⁶ These patients may inexplicably deteriorate or recover suddenly after prolonged, unchanging illness. Similarly, symptoms may appear to worsen acutely when the patient learns of a discharge plan or after they are de-escalated to a lower level of care where they no longer require continuous observation. Patients can demonstrate an inconceivable ability to foresee unexpected changes in their clinical condition. Physicians should be especially suspicious of factitious disorder when a patient is observed intentionally interfering with diagnostic testing.

Patients with factitious disorder are most likely to present with cardiologic, endocrinologic, or dermatologic complaints.² Common cardiac complaints in patients with factitious disorder mirror those seen in the general population, including chest pain, dizziness, hypertension, and shortness of breath. Endocrine complaints include recurrent hypoglycemia, symptoms of Cushing syndrome, and thyrotoxicosis. Technological innovations have provided patients with increased access to medications like insulin, oral antihyperglycemic agents, and thyroid hormones that can cause or simulate specific medical conditions and contribute to these patterns. The most common dermatologic manifestations of factitious disorder include generalized lesions, breast lesions, facial lesions, and leg lesions.⁹ The ease of inducing or simulating a given symptom, such as a skin lesion, likely contributes to a higher frequency of related chief complaints.

Although endocrinologic, cardiologic, and dermatologic concerns are most common, factitious

DSM-5 Diagnostic Criteria for Factitious Disorder

The patient intentionally falsifies physical or psychological signs and symptoms or induces injury or illness.

The individual presents themselves to others as ill, impaired, or injured.

The deceptive behavior is unconnected to external incentives or rewards.

No other mental disorder explains the behavior.

TABLE 1. Diagnosing factitious disorder according to DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th ed.*) criteria

disorder can present with a chief complaint in almost any system. Cases documented in the literature include patients who present with concerns that relate to diverse body systems and specialty practices, including allergy and immunology, obstetrics and gynecology, orthopedics and trauma, urology, and nephrology.² Therefore, although emergency physicians should increase their suspicion for factitious disorder in patients with endocrinologic, cardiologic, or dermatologic complaints, they cannot dismiss the possibility of this disorder when a patient’s clinical presentation relates to any system and makes no sense in the context of their medical record or objective diagnostic testing.

CRITICAL DECISION

What is the differential diagnosis when considering factitious disorder?

The differential diagnosis for factitious disorder includes malingering, various personality disorders (eg, borderline personality disorder or histrionic personality disorder), somatic symptom disorder, and delusional disorder (*Table 2*). It can be confusing to distinguish between these disorders because their associated symptoms or behaviors can be similar or overlapping. Key diagnostic features that distinguish factitious disorder include (1) the intentional and volitional nature of the behavior and (2) the lack of evident secondary gain. Patients with factitious disorder act with an apparent goal of fulfilling the role of a sick person; they are not seeking drugs or other material reward. In their efforts to appear ill, patients frequently assume a significant risk of personal endangerment, either self-imposed or iatrogenic (ie, due to invasive testing and treatment).

Malingering is a separate psychiatric disorder that differs from factitious disorder only by the patient’s intentions and motivation. Malingering individuals perform similar patterns of reported or induced illness or injury; however, they do so with the specific goal of achieving material gain, such as a financial reward from workers’ compensation. Malingering patients are less likely to induce and more likely to simulate their symptoms. Similarly, they are less willing to tolerate painful or intrusive diagnostic testing or treatment options.² Patients with substance use disorders, particularly opioid use disorder, can also present with simulated painful medical conditions for the specific intent of secondary gain — access to their preferred substance.

Personality disorders can also present with behaviors like those seen in factitious disorder but are separated by a more global pattern of maladaptive personality traits. Of the various personality disorders, borderline personality disorder and histrionic personality disorder are most relevant in the differential diagnosis for factitious disorder, given that both conditions can be characterized by self-harm and medical attention-seeking behavior. Patients with borderline personality disorder display a pervasive pattern of instability in their relationships, identity, and affect, often leading to suicidal tendencies or impulsive acts of self-injury.¹⁰ In comparison to patients with borderline personality disorder, those with factitious disorder are more likely to plan and orchestrate specific illness-related symptoms. Patients with borderline personality disorder typically present with random and impulsive attention-seeking or self-destructive behaviors.

Borderline personality disorder is a particularly important diagnostic consideration because it is both relatively common and treatable. It is postulated to have a prevalence of approximately 1.7% in the general population and as high as 20% in some clinical populations, making it significantly more prevalent than factitious disorder.¹¹ In patients with borderline personality disorder, early diagnosis and specific interventions, such as dialectical behavior therapy, are proven to significantly reduce symptom burden.¹²

Disorder	Medical Symptoms	Motivation	Care-Seeking Behavior	Painful or Dangerous Procedures
Borderline personality disorder	Impulsive; self-generated; often related to self-harm	Manifestation of global pattern of dysfunction	Extremely common	Avoided
Delusional disorder (illness anxiety disorder)	Not applicable	Can be unconscious or unintentional	Ubiquitous	Often accepted
Factitious disorder	Intentionally simulated or generated	Desire to fill the role of a sick patient	Ubiquitous	Accepted or actively sought
Histrionic personality disorder	Impulsive; often simulated; grandiose and theatrical	Manifestation of global pattern of dysfunction	Common	Avoided
Malingering	Intentionally simulated or generated	External benefit (eg, financial compensation)	Ubiquitous	Avoided
Somatic symptom disorder	Unintentionally generated; experienced by the patient as organic	Can be unconscious; desire to fill the patient role	Common	Accepted

TABLE 2. Comparison of factitious disorder with other disorders on the differential diagnosis

Histrionic personality disorder is characterized by a consistent need to be the center of attention, often leading to overly sexual, inappropriate, or provocative interactions with others. Patients with histrionic personality disorder are likely to display rapidly shifting and shallow emotions, use physical appearance to draw attention, and consider even the most casual relationships to be intensely intimate. Some attention-seeking behaviors in histrionic personality disorder can mimic the health care-seeking behaviors in factitious disorder. However, reported symptoms in histrionic personality disorder are less specifically designed to simulate specific health conditions and are more often characterized by an exaggerated expression of emotion that is theatrical and self-dramatizing.¹³

Similarly, somatic symptom disorder and delusional disorder are at times confused with factitious disorder. Both conditions can be distinguished from factitious disorder by a lack of intentional deception; the patient fully believes the presenting complaint. Somatic symptom disorder is diagnosed when physical symptoms are unconsciously generated and experienced as real by the patient.^{9,14} To be consistent with somatic symptom disorder, symptoms must cause significant impairment, preventing patients from performing everyday tasks or functions. Patients can experience symptoms in any body system, although pain, neurologic, GI, and sexual complaints are among the most common. Somatic symptom disorder can occur simultaneously with factitious disorder — some patients demonstrate evidence of both conditions.¹⁵

In delusional disorder, patients present with a fixed irrational belief that remains intact despite extensive evidence to the contrary. Some delusions can be health care related, such as an irrational certainty that the patient has developed cancer. Crucially, the delusion must be nonbizarre, meaning that it is possible but implausible. Bizarre delusions, such as a patient believing a microchip has been implanted into their brain by aliens, would more accurately be characterized as a psychotic disorder or other disorder with psychotic features.¹⁶ Delusional disorder related to specific health conditions is also termed *illness anxiety disorder*.

As in somatic symptom disorder, patients with delusional disorder truly believe their condition is real; there are no attempted deceptive behaviors. It is the presence or absence of physical symptomatology that distinguishes somatic symptom disorder from delusional disorder — those with delusional disorder have no significant sensation of bodily dysfunction. For example, delusional disorder would be higher on the differential diagnosis in a patient who has no specific symptoms but is nevertheless convinced that he or she has developed a particular malignancy (eg, glioblastoma). In somatic symptom disorder, a patient would present with some specific physical symptom, such as severe chronic headaches; in this case, the patient's impairment is due to the psychological distress caused by their belief and the consequences (eg, financial or physical) of repeated attempts to achieve validation or diagnosis within the medical system.

CRITICAL DECISION

Why is it important to recognize possible presentations of factitious disorder?

Emergency physicians often represent an early point of contact with health care for patients. Although no recent data exist on the prevalence of factitious disorder in the emergency department, the patient population and patient volume at the emergency department make it likely that emergency physicians will see and treat patients with factitious disorder.

Because early detection of factitious disorder is crucial to preventing iatrogenic harm in patients and limiting the depletion of health care resources, emergency physicians play a particularly important role by

✓ Pearls

- The most common demographic features of a patient with factitious disorder include female sex, early to middle age, employment in health care, and a prior diagnosis of depression.
- Although patients with factitious disorder can present with any chief complaint, visits related to endocrinologic, cardiologic, or dermatologic conditions appear most prevalent.
- Definitively diagnosing factitious disorder is rarely done by emergency physicians, but they do initiate appropriate interventions, such as psychiatric referral or hospitalization in high-risk patients.
- Early identification and treatment of factitious disorder can improve patient outcomes and eliminate unnecessary use of medical resources.
- It can be particularly difficult to identify cases of factitious disorder in peregrinating patients, especially when treating physicians are unable to access existing medical records.

flagging their concern to alert future physicians of the patient's possible diagnosis. Research has shown that early treatment of factitious disorder improves prognoses and outcomes for patients, as well as limits iatrogenic harm, unnecessary treatment, and excessive costs for diagnostic testing.¹⁷ Even in isolated cases, the financial costs associated with factitious disorder can be exorbitant. For example, one patient was identified as having undergone 42 surgical procedures, with 850 admissions through 650 different hospitals.¹⁸

Although recognizing possible cases is important, it is not the role of emergency physicians to diagnose patients with factitious disorder. This condition should be diagnosed only after an extensive process of exclusion in conjunction with advanced neuropsychological testing.⁵ The nature of their specialty prevents emergency physicians from having the volume of data or longitudinal relationship necessary to exclude all other possibilities and definitively diagnose a case of factitious disorder.

Assessing a patient with factitious disorder is a complex endeavor, necessitating the corroboration of multiple independent sources, which can include previous medical records, self-reported patient history, observation of the patient's behavior, and collateral information provided by a patient's friends and family. In rare instances, factitious disorder can be presumptively diagnosed in the emergency department (ie, when a patient is found actively tampering with treatments or testing). Even in these patients, however, the diagnosis is far from certain; physicians must bear in mind the myriad conditions that lead to such behaviors.

Factitious disorder is a difficult diagnosis to assign, particularly because many patients will bounce between different physicians and health care systems to avoid drawing suspicion. Nevertheless, emergency physicians should make note of concerning features, such as an unsubstantiated or atypical presentation, extensive past health care usage, repeated treatment failures, and evidence of intentional misdirection or fabrication of symptoms.² By documenting their observations, emergency physicians alert future physicians to their concerns for factitious disorder in a patient, thereby aiding early diagnosis, improving the prognosis, and decreasing health care costs.

CRITICAL DECISION

How should emergency physicians approach the treatment of patients with suspected factitious disorder?

Concern for factitious disorder should never affect acute medical care or treatment. As always, immediate priority should be given to stabilizing the patient and identifying any possible etiology of symptoms. Given the lack of accurate epidemiologic data and long-term follow-up, no single screening tool or validated diagnostic test for identifying factitious disorder has been developed. Each physician must rely on individual clinical gestalt. If after a thorough medical evaluation the physician still suspects that a patient has factitious disorder, the physician should document these concerns in the medical record.

Emergency presentations of factitious disorder are numerous and diverse, necessitating an awareness of the most common patterns. In one systematic review, the most frequent cardiac complaint was found to be retrosternal chest pain.² Other patients in this cohort simulated ventricular tachycardia by shaking telemetry leads, or they induced hypertension with exogenous substances including epinephrine and amphetamines. Of 59 patients with endocrine complaints, the majority (n=31) had a chief complaint of recurrent hypoglycemia. In 43 identified dermatologic cases, the most common physical manifestations were generalized blisters or ulcers (n=10; including topical application of caustic solutions) and breast lesions (n=7). Dermatologic manifestations may be characterized by an unusual pattern of distribution, particularly in areas easily accessible to the patient like the chest and abdomen. Other common presentations associated with factitious disorder include psychogenic nonepileptic seizures and diarrhea simulated by laxative abuse.²

Patients who present with psychogenic seizures may demonstrate forcefully closed eyes, preservation of self-protective reflexes, and a lack of typical seizure semiology. It is unlikely that these patients will experience tongue biting, fecal or urinary incontinence, or dramatically elevated lactate levels.^{19,20} Nonetheless, these findings remain possible because patients with factitious disorder can research a particular malady to more accurately portray its symptoms. In a patient with nonepileptic seizure-like activity, every effort should be made to avoid the administration of benzodiazepines because of the risk of adverse effects. Patience and communication can be therapeutic. For example, instructing the patient to take deep breaths and stating that this episode should resolve soon can help encourage the patient to cease the behavior. In some cases, a performative aspect of management can be beneficial, such as announcing the necessity of invasive procedures if the seizure-like activity continues. Note that verbalizing that a specific medication, such as a benzodiazepine, is being given while substituting the drug with a placebo is unethical. Physicians should refrain from taking this course of action.