Somatoform and factitious disorders involving the limbs

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Aims of talk

• Define somatoform and factitious disorders
• How to identify them
• Clinical presentations
• Management approaches
Somatoform disorders: definition

- Patients who present with physical symptoms in the absence of any relevant organic disease.
- The symptoms and signs are not intentionally produced and are maintained by psychosocial factors cf. factitious disorders.
- Examples include fibromyalgia, chronic fatigue syndrome, IBS, functional disorders affecting limbs, conversion disorders, CRPS etc.
- Recent introduction of somatic symptom disorder-SSD [DSM-5, 2013]

...think disproportionate pain and disability
Unexplained limb pain/somatoform disorders

[1] Functional weakness ie unexplained weakness and loss of function....[FNSD/conversion disorder]...

[2] Dysfunctional postures of hand and foot [functional dystonia; clenched fist syndrome; equinovarus foot deformity]

[3] CRPS Type 1 referred from pain clinic involved in litigation [disproportionate pain and disability]

[4] Factitious disorder
Conversion disorder; Functional neurological symptom disorder [FNSD]

• Useless right arm of sudden onset in 23 year old woman [video]
Motor abnormalities-Psychoflexed hand [CFS]

- Contraction of fingers without any explanation [frequently 2-3 of the ulnar digits]
- Attempts at passive extension of fingers is painful
- Often preceded by minor injury
- Deformity completely resolves under anaesthesia
- Patient may be involved in medicolegal claim

Weis T and Boeckstyns M. J Hand Surgery [Europ] 2009;34E:3:374
Clenched fist syndrome [CFS]/Psychoflexed hand.
http://dx.doi.org/10.1016/j.bjps.2014.04.027
Complex Regional Pain Syndrome [CRPS Type 1] : origins

• Grew out of “reflex sympathetic dystrophy” or RSD in 1994
• Before that “algodystrophy”
• IASP definition
• Budapest criteria [2007]
CRPS Type 1: Budapest criteria

• “continuing pain that is disproportionate to the inciting event”
• Allodynia [pain to light touch]
• Weakness/tremor

=common, non-specific
“.... CRPS is not associated with a history of pain-preceding psychological problems, or with somatisation and malingering” [Turner-Stokes L et al. Clin Med 2011;11:596-600]
This did not tally with my experience

• Worked in pain Clinic from 1992-2007
• Medicolegal practice from 2005-

• A significant proportion of patients with CRPS had PH of mood disorders, functional syndromes such as IBS, NCCP
• High use of opiates
Vulnerable phenotypes

Depression is a recurrent disorder:
- 1 episode - 50% risk
- 2 episodes - 70% risk
- 3 episodes - 80% risk
- >4 episodes - 90+% risk

Episodes of Functional disorders/syndromes [FSSs]
- CFS
- Fibromyalgia
- Irritable bowel syndrome
- TMJ dysfunction
- Tension headache/migraine
- Non cardiac chest pain [NCCP]
- Chronic pelvic pain

“A network of inter related disorders: Once a person has developed a FSS then there is an increased risk of similar episodes occurring in future” [Warren J et al J psychosom Res 2013; ]
Public perception of CRPS
CRPS Type 1 : Results [2005-2016]

• 50 patients
• Mean age = 42 yrs:
• 30 upper limb
• 20 lower limb
• 10 employed
• 30 in receipt of DLA/PIP
Past history of “painful” disorders [FSSs]

- Defined as:
  - CFS
  - Fibromyalgia
  - Irritable bowel syndrome
  - TMJ dysfunction
  - Painful bladder syndrome /IC
  - Tension headache/migraine
  - Non cardiac chest pain [NCCP]
  - Chronic pelvic pain

“Once a person has developed a FSS then there is an increased risk of similar episodes occurring in future”

Past history of functional somatic syndromes [FSSs]

- 7 [14%] had two
- 14[28%] had >3
- Most common were tension headaches/migraine [20], non cardiac chest pain [17] and IBS [15]
Patients with functional neurological disorders [FNDs] [n=21, 42%]

- Arm=13 [claw hand, tremor, choreoathetoid movements, dystonia]
- Leg=9 [equinovarus foot deformity]
- Spread in 12
- “Alien hand” in 4

Hawley J, Weiner W. Psychogenic dystonia and peripheral trauma. *Neurology* 2011;77:496

CRPS and movement disorders

Van Hilten J. Pain medicine 2010;11:1274
FIG. 505.—Hysterical contracture of hand of fifteen months' duration, cured by suggestion.
Summary: 50 cases of CRPS Type 1

- 30 arm; 20 leg
- 42% history of >2 FSSs eg IBS, NCCP, headache/migraine
- 42% functional neurology eg “claw hand”

- 60% past history of depression
- 20% past history of panic disorder
- 64% on opiates

- 38% diagnostic disagreement between specialists

....“.... CRPS is not associated with a history of pain-preceding psychological problems, or with somatisation and malingering” [Turner-Stokes L. et al Clin Med 2011;11:596-600].
Figure 1

Overlap between CRPS, SSD, and FND

SSD=Somatic Symptom Disorder; FND=Functional Neurological Disorder; CRPS=Complex Regional Pain Syndrome

Bass C, Yates G. submitted, 2017
Complex regional pain syndrome medicalises limb pain
Psychosocial factors may be more important than biomedical ones in type 1 disorder, writes Christopher Bass
CRPS Type 1: contrary views

• “I am amazed how the medical community accepts the mysterious CRPS Type 1: no aetiology, no clear cut signs, no diagnostic test...in the last 15 years I have not referred a hand patient to a pain doctor [1]
• CRPS Type 1 is diagnosed on the basis of non-specific, subjective observations, lacks a consensus reference standard, and may be an illness construction rather than an actual disease (think “whiplash”) [2]
• I have not made the diagnosis of CRPS in 15 years of hand surgery practice at a referral center” [3]
• Experience in Holland November 2016

Recent experience in Holland:2016

- Disuse due to immobilization can give an identical clinical picture, including the inflammatory parameters that are seen in CRPS-1. CRPS-1 following injury can be prevented with exercise, and incidence is declining dramatically. Taking these factors into consideration, we support the view that CRPS-1 is not an illness but rather a 'disuse syndrome' as a result of immobilization, or there may be a missed underlying diagnosis.

Frolke JP et al. Ned Tijschr Geneesk;159:A8370
CRPS Type 1:negating the myth
......abnormal diagnostic behaviour, which leads to abnormal illness behaviour in the patients and is invariably compounded by abnormal treatment behaviour...

Kouyanou K, Pither C, Wessely S
Iatrogenic factors and chronic pain.
Psychosomatic Med 1997;59:597-604
Take home messages

1] Biased sample?
2] Mechanisms
3] Terminology
4] Need for more detailed psychosocial assessment of CRPS cases
Nomenclature

• What's wrong with armache?
• We have backache, neckache, headache...
• Or non-specific pain??

• “...The words used in clinical medicine have a tremendous influence on the subject they describe or purport to describe.....” Asher R. Talking Sense, London Pitman, 1972.
• “...Common hand surgery words have a relatively negative emotional content...” Vranceanu A et al. Hand 2012;7:293-6.
Advantages of a non-specific diagnosis [follow up of 634 cases]

- More accurate
- Better representation of current best evidence and best care
- More adequately characterises the pre-test odds of finding discrete pathology
- Low risk of iatrogenic harm
- Encourage adaptation to the limits of modern medicine and development of self efficacy

Factitious disorders of the extremities: management
Factitious disorder imposed on self [DSM-5:300.19,2013] [ICD-10:F68.10]

Factitious disorder imposed on self:

• A Falsification of physical or psychological signs or sx, or induction of injury or disease, associated with identified deception
• B The individual presents himself or herself to others as ill, impaired or injured
• C The deceptive behaviour is evident even in the absence of obvious external rewards
• D The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
Factitious disorder of hand: Pitting oedema and use of tourniquet
Supportive confrontation: preparation

- Discuss with physician/surgeon (or hospital legal team if none available)
- Meet with colleague and marshall facts; discuss strategy
- CONFRONTATION with patient should be non-judgemental, non-punitive
- Propose ongoing support/ follow up
- If health care worker discuss with MDU, MPS
- Discuss with patient’s GP; document in notes
Non confrontational including “double bind”

• ‘face saving’

• Double bind:
  – “We have excluded every possible cause for this so now we expect this muscle flap to be successful. If it were not then we would be very puzzled and might worry that there was another explanation...”

• Also includes tactics like “is it possible you might scratch or touch this wound by accident in your sleep?”
If the patient is a health care worker

- Phone your hospital legal services for advice
- Telephone the MDU or MPS
- Discuss with patient’s GP
- Copy the MDU/MPS into all your written correspondence
- Obligation to inform GMC, UKCC, medical school, registering body etc of the patient
- Patient may constitute a risk to public safety
Outcome

- Poor
- Only 1 in 6 acknowledge their deceptions
- Less than 10% engage in psychological treatment
- Many continue their deceptions in different hospitals

Bass C Taylor M. *Personality and Mental Health* 2013;7:80-3

Factitious disorders and malingering: challenges for clinical assessment and management

Christopher Bass, Peter Halligan

Compared with other psychiatric disorders, diagnosis of factitious disorders is rare, with identification largely dependent on the systematic collection of relevant information, including a detailed chronology and scrutiny of the patient’s medical record. Management of such disorders ideally requires a team-based approach and close involvement of the
Summary

• Uncommon but important
• Clues include inexplicable non-healing wounds, multiple polymicrobial infections and histology showing positive birefringence or reactions to foreign material (but beware atypical mycobacteria and other “funnies”)
• Multi-disciplinary assessment and support is essential: do not go back to your ward or clinic and carry out a supportive confrontation alone!

Systematic review of world literature [455 cases]

• Average age 34 years
• More often female, 66%
• Health care workers 57% [of 122]
• Depression>Personality disorder [42% v 17%]
• Self induction>simulation or false report
• Endocrine, cardiac, dermatology

Evidence-based medicine: disproportionate pain and disability.
Ring D, Barth R, Barsky A.
*J Hand Surg Am* 2010;35(8):1345-7

Less specific arm illnesses*
Vranceanu A, Barsky A, Ring D.
*J Hand Therapy* 2011;24:118-23

Streamlined classification of psychopathological hand disorders: a literature review.
Eldridge M, Grunert B, Matloub H.

Explaining functional disorders in the neurology clinic: a photo story
Carson A et al

Factitious disorders of the upper limb
Burke F
*J Hand Surg Eur* 2008;33:102-9

Factitious disorders and malingering: challenges for clinical assessment and management
Bass C, Halligan P

Factitious disorder: a systematic review of 455 cases in the professional literature.
Yates G, Feldman M
*Gen Hosp Psychiatry* 2016;41:20-28